**Medicare Summary Notice to Remittance Advice Messages Map**
**July 1998**
**Division of Health Care Information Systems Standards**
**Office of Information Services**
**Health Care Financing Administration**

## Introduction

HCFA has periodically issued maps between the standard messages used to notify beneficiaries of decisions on their Medicare claims and the corresponding messages used to notify their providers of health care of the decisions made on those same claims. Previous maps have been between the Explanation of Medicare Benefit (EOMB) messages and the provider remittance advice claim adjustment reason codes and remark codes. The new map in attachment 1 is between the Medicare Summary Notice (MSN) messages, which are replacing the EOMB messages, and the provider remittance advice messages.

This map is intended to assist standard systems and others who have a need to program to or between the different message sets. We expect to update this map periodically in the future to reflect changes/additions to the message sets. Questions concerning the maps, or suggestions for changes to the maps, should be submitted to the regional electronic data interchange (EDI) coordinators for routing to DHCISS in HCFA's central office.

Attachment 1 is organized in MSN message number order, with the applicable reason and/or remark code message number(s) following each MSN message. In response to requests for more guidance on the use of group codes, which must be used in most formats with reason codes to identify liability for amounts not paid by Medicare, this map also includes group codes where that group is clearly indicated by the nature of the message. However, group codes are not listed in those cases where more than one group might apply according to a contractors coverage or medical policies. In those cases, contractors and standard systems must determine the appropriate group code for their situation.

The Accredited Standards Committee (ASC) X12N (health insurance) reason codes (attachment 2) and the Medicare remark codes (attachment 3) to which the MSN messages are mapped are also included for your reference. Medicare carriers and intermediaries are limited to use of these reason and remark codes to report claim and service adjustments and remarks in their electronic and paper remittance advices; they are prohibited from using reason or remark messages that are not included in these lists, or which have not otherwise been published for their use by HCFA.

Reason and remark codes must be used in remittance advice transactions when they apply. Medicare carriers and intermediaries and their standard systems may use discretion to determine when particular codes may apply, they do not have discretion as to whether to use applicable codes and messages.

**Attachment 1**

**SECTIONS SHOWING APPROVED MESSAGES FOR THE MSN:**

| | |
|---|---|
| 1 | Ambulance |
| 2 | Blood |
| 3 | Chiropractic |
| 4 | End-Stage Renal Disease (ESRD) |
| 5 | Number/Name/Enrollment |
| 6 | Drugs |
| 7 | Duplicate Bills |
| 8 | Durable Medical Equipment (DME) |
| 9 | Failure to Furnish Information |
| 10 | Foot Care |
| 11 | Transfer of Claims or Parts of Claims |
| 12 | Hearing Aids |
| 13 | Skilled Nursing Facility |
| 14 | Laboratory |
| 15 | Medical Necessity |
| 16 | Miscellaneous |
| 17 | Non Physician Services |
| 18 | Preventive Care |
| 19 | Hospital Based Physician Services |
| 20 | Benefit Limits |
| 21 | Restrictions to Coverage |
| 22 | Split Claims |
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| 25 | Time Limit for filing |
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| 27 | Hospice |
| 28 | Mandatory Assignment for Physician Services Furnished Medicaid Patients |
| 29 | MSP |
| 30 | Reasonable Charge and Fee Schedule |
| 31 | Adjustments |
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| 34 | Patient Paid/Split Payments |
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| 38 | General Information |
| 39 | Add-on Messages |
| 40 | Mandated Messages |
| 41 | Home Health Messages |
| 60 | Demonstration Project Messages |

## AMBULANCE

1.1 - Payment for transportation is allowed only to the closest facility that can provide the necessary care.--117

1.2 - Payment is denied because the ambulance company is not approved by Medicare.--B7

1.3 - Ambulance service to a funeral home is not covered.--46

1.4 - Transportation in a vehicle other than an ambulance is not covered.--46

1.5 - Transportation to a facility to be closer to home or family is not covered.--46

1.6 - This service is included in the allowance for the ambulance transportation.--CO 97

1.7 - Ambulance services to or from a doctor's office are not covered.--46

1.8 - This service is denied because you refused to be transported.--CO 112

1.9 - Payment for ambulance services does not include mileage when you were not in the ambulance.--CO 112

1.10 - Air ambulance is not covered since you were not taken to the airport by ambulance.--57

1.11 - The information provided does not support the need for an air ambulance. The approved amount is based on ground ambulance.--57

## BLOOD

2.1- The first three pints of blood used in each year are not covered.--PR 66

2.2 - Charges for replaced blood are not covered.--CO 46

## CHIROPRACTIC

3.1 - This service is covered only when recent x-rays support the need for the service.--CO 50 with M1

## ESRD

4.1 - This charge is more than Medicare pays for maintenance treatment of renal disease.--CO42

4.2 - This service is covered up to (insert appropriate number) months after transplant and release from the hospital.-- Not used on remittance advice unless service being denied as exceeding this limit, in which case PR 35 would apply.

4.3 - Prescriptions for immunosuppressive drugs are limited to a 30-day supply.-- As in 4.2

4.4 - Only one supplier per month may be paid for these supplies/services.--B 20

4.5 - Medicare pays the professional part of this charge to the hospital.--CO 89

4.6 - Payment has been reduced by the number of days you were not in the usual place of treatment.--B 20

4.7 - Payment for all equipment and supplies is made through your dialysis center. They will bill Medicare for these services.--24

4.8 - This service cannot be paid because you did not choose an option for your dialysis equipment and supplies.--106

4.9 - Payment was reduced or denied because the monthly maximum allowance for this home dialysis equipment and supplies has been reached.--CO 42

4.10 - No more than ( $ ) can be paid for these supplies each month. (NOTE: Insert appropriate dollar amount.)--Only applies to Remittance Advices (RA)s to the extent service is denied or reduced as a limit exceeded, 42.

4.11- The amount listed in the 'You May Be Billed' column is based on the Medicare approved amount. You are not responsible for the difference between the amount charged and the amount charged and the approved amount.-- This correlates to the CO group code in an RA.

**NAME / NUMBER / ENROLLMENT**

5.1 - Our records show that you do not have Medicare entitlement under the number shown on this notice. If you do not agree, please contact your local Social Security office.--PR 31

5.2 - The name or Medicare number was incorrect or missing. Please check your Medicare card. If the information on this notice is different from your card, contact your provider.--PR 31

5.3 - Our records show that the date of death was before the date of service.--13

5.4 - If you cash the enclosed check, you are legally obligated to make payment for these services. If you do not wish to assume this obligation, please return this check.--When this is sent to a beneficiary or estate, use PR100 on RA to notify provider that the beneficiary/estate was paid.

5.5 - Our records show you did not have Part A (B) coverage when you received this service. If you disagree, please contact us at the customer service number shown on this notice.--PR 31

5.6 - The name or Medicare number was incorrect or missing. Ask your provider to use the name or number shown on this notice for future claims.--MA 27 (claim level remark code) use with payment.

**DRUGS**

6.1 - This drug is covered only when Medicare pays for the transplant.--PR 107

6.2 - Drugs not specifically classified as effective by the Food and Drug Administration are not covered.-- 114

6.3 - Payment cannot be made for oral drugs that do not have the same active ingredients as they would have if given by injection.--PR 46

6.4 - Medicare does not pay for an oral anti-emetic drug that is not administered for use immediately before, at or within 48 hours after administration of a Medicare covered chemotherapy drug.--PR 96 with M100

**DUPLICATES**

7.1 - This is a duplicate of a charge already submitted.--CO 18

7.2 - This is a duplicate of a claim processed by another contractor. You should receive a Medicare Summary Notice from them.--CO 18 with M43

**DURABLE MEDICAL EQUIPMENT**

8.1 - Your supplier is responsible for the servicing and repair of your rented equipment.--M6 with payment information, or if denial of repair bill, use M6 with CO 46.

8.2 - To receive Medicare payment, you must have a doctor’s prescription before you rent or purchase this equipment.--CO B17

8.3 - This equipment is not covered because its primary use is not for medical purposes.--46

8.4 - Payment cannot be made for equipment that is the same or similar to equipment already being used.--CO 57 with M3

8.5 - Rented equipment that is no longer needed or used is not covered.--CO 57

8.6 - A partial payment has been made because the purchase allowance has been reached. No further rental payments can be made.--CO 35

8.7 - This equipment is covered only if rented.--CO 108

8.8 - This equipment is covered only if purchased.--CO 108

8.9 - Payment has been reduced by the amount already paid for the rental of this equipment.--CO B13

8.10 - Payment is included in the approved amount for other equipment.--CO 97

8.11 - The purchase allowance has been reached. If you continue to rent this piece of equipment, the rental charges are your responsibility.--PR 35 and M7 for a denial, or M7 alone with the entry for the last rental payment if used as a warning.

8.12 - The approved charge is based on the amount of oxygen prescribed by the doctor.--CO 57

8.13 - Monthly rental payments can be made for up to 15 months from the first paid rental month or until the equipment is no longer needed, whichever comes first.--M5 with rental denial reason code or payment information

8.14 - Your equipment supplier must furnish and service this item for as long as you continue to need it. Medicare will pay for maintenance and/or servicing for every 6 month period after the end of the 15th paid rental month.--M6 with denial of maintenance/repair claim or with payment of rental bill

8.15 - Maintenance and/or servicing of this item is not covered until 6 months after the end of the 15th paid rental month.--CO 30 denial reason code with M6

8.16 - The approved amount includes payment for all covered stationary oxygen equipment, contents and accessory items for an entire rental month.--No RA message; the items covered by the payment would be reflected on the RA by the HCPCS and the dates of service.

8.17 - Payment for this item is included in the monthly rental payment amount.--CO 97

8.18 - Payment is denied because the supplier did not have a written order from your doctor prior to delivery of this item.--B17

8.19 - Sales tax is included in the approved amount for this item--CO 97.

8.20- Medicare does not pay for this equipment or item.--46

8.21 - This item cannot be paid without a new, revised or renewed certificate of medical necessity.--CO B17

8.22 - No further payment can be made because the cost of repairs has equaled the purchase price of this item.--35

8.23 - No payment can be made because the item has reached the 15 month limit. Separate payments can be made for maintenance or servicing every 6 months.--CO 35 with M6

8.24 - The claim does not show that you own or are purchasing the equipment requiring these parts or supplies.--CO D3

8.25 - Payment cannot be made until you tell your supplier whether you want to rent or buy this equipment.--4 (Note: RR modifier = rental; NV modifier = purchase of new DME; UE modifier= purchase of used DME)

8.26 - Payment is reduced by 25% beginning the 4th month of rental.--CO 42

8.27 - Payment is limited to 13 monthly rental payments because you have decided to purchase this equipment.--CO 35 with M7

8.28 - Maintenance, servicing, replacement or repair of this item is not covered.--46

8.29 - Payment is allowed only for the seat lift mechanism, not the entire chair.--42 with payment under the downcoded HCPCS for the mechanism in SVC01-02 and the billed chair HCPCS in SVC06-02.

8.30 - This item is not covered because the doctor did not complete the certificate of medical necessity.--CO B17

8.31 - Payment is denied because blood gas tests cannot be performed by a durable medical equipment supplier.--CO B5 with M8

8.32 - This item can only be rented for two months. If the item is still needed, it must be purchased.--CO 108

8.33 - This is the next to last payment for this item.--M5 with payment information

8.34 - This is the last payment for this item.--M4 with payment information

8.35 - This item is not covered when oxygen is not being used.--CO 50

8.36 - Payment is denied because the certificate of medical necessity on file was not in effect for this date of service.--CO B17

8.37 - An oxygen recertification form was sent to the physician.--M19 to physician with CO B17 if claim denied for lack of oxygen receipt, or M19 with payment data if form requested as a condition for future payment.

8.38 - This item must be rented for two months prior to purchasing it.--CO 108

8.39 - This is the 10th month of rental payment. Your supplier should offer you the choice of changing the rental to a purchase agreement.--M9 with payment data

8.40 - We have previously paid for the purchase of this item.--CO 18 with M3

8.41 - Payment for the amount of oxygen supplied has been reduced or denied because the monthly limit has been reached.--CO 119

8.42 - Standby equipment is not covered.--CO 50

8.43 - Payment has been denied because this equipment cannot deliver the liters per minute prescribed by your doctor.--CO 57

8.44 - Payment is based on a standard item because information did not support the need for a deluxe or more expensive item.--42 with M25

8.45 - Payment for electric wheelchairs is allowed only if the purchase decision is made in the first or tenth month of rental.--108 with M10

8.46 - Payment is included in the allowance for another item or service provided at the same time.--CO B15

8.47 - Supplies or accessories used with noncovered equipment are not covered.--107

8.48 - Payment for this drug is denied because the need for the equipment has not been established.--CO 50

8.49 - This allowance has been reduced because part of this item was paid on another claim.--CO B13

8.50 - Medicare cannot pay for this drug/equipment because our records do not show your supplier is licensed to dispense prescription drugs, and, therefore, cannot assure the safety and effectiveness of the drug/equipment. You are not financially liable for any amount for this drug/equipment unless your supplier gave you a written notice in advance that Medicare would not pay for it and you agreed to pay.-- CO B7

## FAILURE TO FURNISH INFORMATION

9.1 - The information we requested was not received.--CO 17

9.2 - This item or service was denied because information required to make payment was missing.--CO 16

9.3 - Please ask your provider to submit a new, complete claim to us. (NOTE: Add-on to other messages as appropriate)-- 16. When using 16, should also use a claim remark code such as a return/reject code (MA 29-MA 43, etc.) to show why claim rejected as incomplete.

9.4 - This item or service was denied because information required to make payment was incorrect.--RA message depends on what is incorrect, e.g., B18 if procedure code or modifier is incorrect, 125 if submission/billing error, A8 if ungroupable DRG; 4-12 for different inconsistencies.

9.5 - Our records show your doctor did not order this supply or amount of supplies.--CO 57

9.6 - Please ask your provider to resubmit this claim with a breakdown of the charges or services.--CO 16 with M79

9.7 - We have asked your provider to resubmit the claim with the missing or correct information. (NOTE: Add-on to other messages as appropriate)--CO 16 with applicable remark code for the missing/incorrect information

9.8- The hospital has been asked to submit additional information, you should not be billed at this time.--CO 16

## FOOT CARE

10.1 - Shoes are only covered as part of a leg brace.--PR 46

## TRANSFER OF CLAIMS

11.1 - Your claim has been forwarded to the correct Medicare contractor for processing. You will receive a notice from them. (NOTE: Use for Carriers, Intermediaries, RRB, United Mine Workers)--CA B11

11.2 - This information is being sent to Medicaid. They will review it to see if additional benefits can be paid.--MA07

11.3 - Our records show that you are enrolled in a health maintenance organization. Your provider must bill this service to them.--OA 120

11.4 - Our records show that you are enrolled in a health maintenance organization. Your claim was sent to them for processing.--OA B11

11.5 - This claim will need to be submitted to (another carrier, a durable medical equipment regional carrier (DMERC), Medicaid agency).--OA 109

11.6 - We have asked your provider to resubmit this claim to the proper carrier (intermediary). That carrier (intermediary) is (name and address of carrier, intermediary or durable medical equipment regional carrier, etc.)--OA 109

## HEARING AIDS

12.1 - Hearing aids are not covered.--PR 46

## SKILLED NURSING FACILITY

13.1 - No qualifying hospital stay dates were shown for this Skilled Nursing Facility stay.--A6

13.2 - Skilled Nursing Facility benefits are only available after a hospital stay of at least 3 days.--A6

13.3 - Information provided does not support the need for skilled nursing facility care.--50

13.4 - Information provided does not support the need for continued care in a skilled nursing facility.--50

13.5 - You were not admitted to the skilled nursing facility within 30 days of your hospital discharge.--A6

13.6 - Rural primary care skilled nursing facility benefits are only available after a hospital stay of at least 2 days.--A6

## LABORATORY

14.1 - The laboratory is not approved for this type of test.--CO B7

14.2 - Medicare approved less for this individual test because is can be done as part of a complete group of tests.--CO 42 with M75

14.3 - Services or items not approved by the Food and Drug Administration are not covered.--CO 114

14.4 - Payment denied because the claim did not show who performed the test and/or the amount charged.--CO D12

14.5 - Payment denied because the claim did not show if the test was purchased by the physician or if the physician performed the test.--CO 16 with M12

14.6 - This test must be billed by the laboratory that did the work.--CO B20

14.7 - This service is paid at 100% of the Medicare approved amount. (NOTE: Mandated message - This message must appear on all service lines paid at 100% of the Medicare approved amount.)--Would be reflected on RA by payment amount which equals the shown allowed amount, not by a separate message.

14.8 - Payment cannot be made because the physician has a financial relationship with the laboratory.--CO D13

14.9 - Medicare cannot pay for this service for the diagnosis shown on the claim.--B22

14.10 -Medicare does not allow a separate payment for EKG readings.--CO B15

14.11 - A travel allowance is paid only when a covered specimen collection fee is billed.--CO 107

14.12 -Payment for transportation can only be made if an X-ray or EKG is performed.--CO 107

14.13 -The laboratory was not approved for this test on the date it was performed.--CO B7

## MEDICAL NECESSITY

15.1 - The information provided does not support the need for this many services or items.--CO 57

15.2 - The information provided does not support the need for this equipment.--CO 50

15.3 - The information provided does not support the need for the special features of this equipment.--CO 50

15.4 - The information provided does not support the need for this service or item.--CO 50

15.5 - The information provided does not support the need for similar services by more than one doctor during the same time period.--CO B20 with M86

15.6 - The information provided does not support the need for this many services or items within this period of time.--CO 57

15.7 - The information provided does not support the need for more than one visit a day.--CO 57

15.8 - The information provided does not support the level of service as shown on the claim.--CO 57

15.9 - The PEER Review Organization did not approve this service.--CO 15 if the denial is the result of the provider's failure to request PRO approval, or CO 39 if the denial is the result of PRO review and disapproval

15.10 - Medicare does not pay for more than one assistant surgeon for this procedure.--CO 54

15.11 -Medicare does not pay for an assistant surgeon for this procedure/surgery.--CO 54

15.12 -Medicare does not pay for two surgeons for this procedure.--CO 54

15.13 -Medicare does not pay for team surgeons for this procedure.--CO 54

15.14 -Medicare does not pay for acupuncture.--48

15.15 -Payment has been reduced because information provided does not support the need for this item as billed.--CO 57

15.16 -Your claim was reviewed by our Medical Staff. (NOTE: Add-on to other messages as appropriate).--M85 if review of physician evaluation and management services M87 if subjected to CFO-CAP prepayment review; M92 if HH Medical Review; M95 if HH initiative MR/Cost report audit.

15.17 -We have approved this service at a reduced level. (NOTE: Add-on to other messages as appropriate)--Would not generally apply to an RA, only on MSN. RA would report the reason for the reduction.

## MISCELLANEOUS

16.1 - This service cannot be approved because the date on the claim shows it was billed before it was provided.--CO 110 with M58

16.2 - This service cannot be paid when provided in this location/facility.--CO 58

16.3 - The claim did not show that this service or item was prescribed by your doctor.--CO B17

16.4 - This service requires prior approval by the PEER Review Organization.--CO 15

16.5 - This service cannot be approved without a treatment plan by a physical or occupational therapist.--CO D14

16.6 - This item or service cannot be paid unless the provider accepts assignment.--CO 111

16.7 - Your provider must complete and submit your claim.--Message would only be sent on MSN, not RA.

16.8 - Payment is included in another service received on the same day.--CO B15

16.9 - This allowance has been reduced by the amount previously paid for a related procedure.--CO B10

16.10 -Medicare does not pay for this item or service.-- 46

16.11 -Payment was reduced for late filing. You cannot be billed for the reduction. (NOTE: Mandated message - This message must print on all service lines subject to the 10% reduction.)--Since a late filing reduction is imposed on a provider and not on a beneficiary, a late filing reduction would be shown as a provider level adjustment reason code (LF) on a RA.

16.12 -Outpatient mental health services are paid at 50 percent of the approved charges. (NOTE: Mandated message - This message must print on all service lines subject to the outpatient psychiatric reduction.)--PR 122

16.13 -The code(s) your provider used is/are not valid for the date of service billed.--CO B18 with M58

16.14 -The attached check replaces your previous check (#) dated ___ .--Not a RA message code. Replacement check indicator would be reported with code RI in a PLB Provider Adjustment Reason Code data element.

16.15 - The attached check replaces your previous check. (NOTE: Use only if prior check information is not accessible by the system.)--Use RI in PLB segment.

16.16 -As requested, this is a duplicate copy of your Medicare Summary Notice.--Not applicable to RA. If replacement check issued to provider, use MA 74.

16.17 -Medicare does not pay for these services when they are not given in conjunction with total parenteral nutrition.--107

16.18 -Service provided prior to the onset date of certified parenteral/enteral nutrition therapy is not covered.--CO B17

16.19- The approved amount of this parenteral/enteral nutrition supply is based on a less extensive level of care for the nature of the diagnosis stated.--CO B22

16.20 -The approved payment for calories/grams is the most Medicare may allow for the diagnosis stated.--CO B22

16.21 -The procedure code was changed to reflect the actual service rendered.--CO 57 with paid HCPCS in SVC01 and billed HCPCS in SVC06.

16.22 -Medicare does not pay for services when no charge is indicated.--CO 16 with M79

16.23 -This check is for the excess amount you paid toward a prior overpayment.--The provider would not be notified when such a refund is issued to a beneficiary.

16.24 -Services provided aboard a ship are covered only when the ship is of United States registry and is in United States waters. In addition, the service must be provided by a doctor licensed to practice in the United States.--PR 113

16.25 -Medicare does not pay for this much equipment, or this many services or supplies.--CO 57 if denied as this quantity is not medically necessary.

16.26 -Medicare does not pay for services or items related to a procedure that has not been approved or billed.--CO 107 with M58

16.27 -This service is not covered since our records show you were in the hospital at this time.--CO 60 with M2

16.28 -Medicare does not pay for services or equipment that you have not received.--112

16.29 -Payment is included in another service you have received.--CO B15

16.30 -Services billed separately on this claim have been combined under this procedure.--CO B15 with M15

16.31 -You are responsible to pay the primary physician care the agreed monthly charge.--Beneficiary obligation to pay a provider is shown by use of a PR code on the RA with the reason code to show why the amount not covered by Medicare.

16.32 -Medicare does not pay separately for this service.--CO B15

16.33 -Your payment includes interest because Medicare exceeded processing time limits. (NOTE: Mandated message - This message must print claim level if interest is added into the beneficiary payment amount for unassigned or split pay claims.) --Interest paid to a beneficiary on a non-assigned claim should not be reported to a provider on a RA. Interest paid to the provider would appear at the PLB level.

16.34 -You should not be billed for this service. You do not have to pay this amount. (NOTE: Add-on to other messages, or use individually as appropriate.)--Reflected by use of CO group code on RA.

16.35 -You do not have to pay this amount. (NOTE: Add-on to other messages as appropriate.) --CO group code with the claim adjustment reason code and amount.

16.36 -If you have already paid it, you are entitled to a refund from this provider. (NOTE: Add-on to other messages as appropriate.)--M 26 or MA 72 , depending on whether a line level or claim level message is needed for the situation.

16.37 -Please see the back of this notice. (NOTE: Add-on to other messages as you feel appropriate.)--Not applicable to a RA.

16.38 -Charges are not incurred for leave of absence days.--CO 112

16.39 - Only one provider can be paid for this service per calendar month. Payment has already been made to another provider for this service.--B20

16.40 -Only one inpatient service per day is allowed.--CO B14 if denying more than one physician visit to an inpatient per day with M63.

16.41 - Payment is being denied because you refused to request reimbursement under your Medicare benefits.--PR 106

16.42 - The provider’s determination of noncoverage is correct.--This would be sent to the beneficiary when a demand bill was processed for SNF care. The RA would deny as PR 50, stay not medically necessary.

16.43 -This service cannot be approved without a treatment plan and supervision of a doctor.--D15

16.44 -Routine care is not covered.--PR 49

16.45 -You cannot be billed separately for this item or service. You do not have to pay this amount.--CO B15

16.46 - Medicare payment limits do not affect a Native American's right to free care at Indian Health Institutions.--The message would only be sent to a beneficiary; not to a provider.

16.47- When deductible is applied to outpatient psychiatric services, you may be billed for up to the approved amount. The "You May Be Billed" column will tell you the correct amount to pay your provider.--PR 122

## NON-PHYSICIAN SERVICES

17.1 - Services performed by a private duty nurse are not covered.--46

17.2 - This anesthesia service must be billed by a doctor.--No RA message would be sent to Dr. unless that Dr. had billed Medicare. This would only be sent on MSN.

17.3 - This service was denied because you did not receive it under the direct supervision of a doctor.--D15

17.4 - Services performed by an audiologist are not covered except for diagnostic procedures.--PR 46

17.5 - Your provider's employer must file this claim and agree to accept assignment.--CO 111 with M40

17.6 - Full payment was not made for this services because the yearly limit has been met.--PR 119

17.7 - This service must be performed by a licensed clinical social worker.--B6

17.8 - Payment was denied because the maximum benefit allowance has been reached.--PR 35

17.9 - Medicare (Part A / Part B ) pays for this service. The provider must bill the correct Medicare contractor. (NOTE: Insert appropriate program. Message is used for Part A claims received by Part B or Part B claims received by Part A.)--OA 109

17.10 -The allowance has been reduced because the anesthesiologist medically directed concurrent procedures.--CO 59

17.11 -This item or service cannot be paid as billed.--16 with remark code as appropriate to identify the reason it cannot be paid as billed.

17.12 -This service is not covered when provided by an independent therapist.--B6

17.13 -Medicare approves up to ( $ ) a year for services billed by a physical or occupational therapist. (NOTE: Insert appropriate dollar amount.)--PR 119 with the amount not covered as in excess of the annual limit.

17.14 -Charges for maintenance therapy are not covered.--46

17.15 -This service cannot be paid unless certified by your physician every ( ) days. (NOTE: Insert appropriate number of days.)--B17

**PREVENTIVE CARE**

18.1 - Routine examinations and related services not covered.--PR 49

18.2 - This immunization and/or preventive care is not covered.--PR 49

18.3 - Screening mammography is not covered for women under 35 years of age.--6 with M37

18.4 - This service is being denied because it has not been 12 months since your last examination of this kind. (NOTE: Insert appropriate number of months.)--119 with M90

18.5 - Medicare will pay for another screening mammogram in (12, 24) months. (NOTE: Insert appropriate number of months.)--Not used in RA, only 119 with M90

18.6 - A screening mammography is covered only once for women age 35 - 39.--119 with M89

18.7 - Screening pap smears are covered only once every 36 months unless high risk factors are present.--119 with M83

18.8 - Screening mammograms are covered for women 40 - 49 years of age without high risk factors only once every 24 months.--119 with M83

18.9 - Screening mammograms are covered for women 40 - 49 years of age with high risk factors only once every 12 months.--119 with M90

18.10 -Screening mammograms are covered for women 50 - 64 years of age once every 12 months.--119 with M90

18.11 -Screening mammograms are covered for women 65 years of age and older only once every 24 months.--119

18.12 Screening mammograms are covered annually for woman 40 years of age and older.--M90 with payment or denial reason code.

18.13 This service is not covered for beneficiaries under 50 years of age.--6 with M82

18.14 Service is being denied because it has not been (12,24,48) months since your last (test/procedure) of this kind.--119 with M90 for 12 months. No remark code for 24 or 48 months (that should be addressed in coverage policy).

18.15 Medicare only covers this procedure for beneficiaries considered to be at high risk for colorectal cancer.--48 with M83

18.16 This service is being denied because payment has already been made for a similar procedure within a set time frame.--119 with M86

18.17 Medicare pays for screening Pap smear and/or screening pelvic examination only once every 3 years unless high risk factors are present.--119 when used as a denial message, would not appear in an RA solely as a coverage message.

18.18 Medicare does not pay for this service separately since payment of it is included in our allowance for other services you received on the same day.--CO 97

## HOSPITAL BASED PHYSICIANS

19.1 - Services of a hospital based specialist are not covered unless there is an agreement between the hospital and the specialist.--CO B20 with MA12

19.2 - Payment was reduced because this service was performed in a hospital outpatient setting rather than a provider’s office.--CO B6

19.3 - Only one hospital visit or consultation per provider is allowed per day.--CO B14

## BENEFIT LIMITS

20.1 - You have used all of your benefit days for this period.--PR 119 with covered days in MIA 01.

20.2 - You have reached your limit of 190 days of psychiatric hospital services.--PR 35 with lifetime psychiatric days in MIA03.

20.3 - You have reached your limit of 60 lifetime reserve days.--PR 35 with lifetime reserve days used in QTY01.

20.4 - ( ) of the Benefit Days Used were charged to your Lifetime Reserve Day benefit. (NOTE: Mandated message - This message must be printed claim level when all or a portion of the Benefit Days Used are charged to the Lifetime Reserve Day benefit.)--Would be shown with a LA qualifier in the QTY segment of an RA.

20.5 - These services cannot be paid because your benefits are exhausted at this time.--PR 35 if totally exhausted or 119 if exhausted for this period.

20.6 - Days used has been reduced by the primary group insurer's payment.--Message would not be used on RA, the days calculated as used would simply be reported in MIA01, MIA03 or QTY02 as appropriate.

20.7 - You have ____ day(s) remaining of your 190 day psychiatric limit.--Days used, not days remaining, are reported in RA (MIA03)

20.8 Days used are being subtracted from your total (inpatient or skilled nursing facility) benefits for this benefit period.--Reflected by entry in MIA01

20.9 Services after mm/dd/yy cannot be paid because your benefits were exhausted.--On RA, use PR35 with the # of covered days.

## RESTRICTION TO COVERAGE

21.1 - Services performed by an immediate relative or a member of the same household are not covered.--CO 53

21.2 - The provider of this service is not eligible to receive Medicare payments.--38

21.3 - This provider was not covered by Medicare when you received this service.--B7

21.4 - Services provided outside the United States are not covered. See your Medicare Handbook for services received in Canada and Mexico.--PR 113

21.5 - Services needed as a result of war are not covered.--PR 113

21.6 - This item or service is not covered when performed, referred or ordered by this provider.--52 for referring/ordering or 38 for performed by.

21.7 - This service should be included on your inpatient bill.--60 with M48

21.8 - Services performed using equipment that has not been approved by the Food and Drug Administration are not covered.--114

21.9 - Payment cannot be made for unauthorized service outside the managed care plan.--120

21.10 -A surgical assistant is not covered for this place and/or date of service.--CO 54

21.11 -This service was not covered by Medicare at the time you received it.--26

21.12 -This hospital service was not covered because the attending physician was not eligible to receive Medicare benefits at the time the service was performed.--52

21.13 -This surgery was not covered because the attending physician was not eligible to receive Medicare benefits at the time the service was performed.--52

21.14 -Medicare cannot pay for this investigational device because the FDA clinical trial period has not begun.--114

21.15 -Medicare cannot pay for this investigational device because the FDA clinical trial period has ended.--114 with M61

21.16 -Medicare does not pay for this investigational device.--55

21.17 -Your provider submitted noncovered charges for which you are responsible.--PR 96

21.18 -This item or service is not covered when performed or ordered by this provider.--52

21.19 -This provider decided to drop out of Medicare. No payment can be made for this service, you are responsible for this charge. Under Federal law your doctor cannot charge you more than the limiting charge amount.--PR 38 with MA56

21.20 - The provider decided to drop out of Medicare. No payment can be made for this service, you are responsible for this charge.--PR 38 with MA47

## SPLIT CLAIMS

22.1 - Your claim was separated for processing. The remaining services may appear on a separate notice. (NOTE: Mandated message - This message must print claim level on all split claims, including the original and replicate claim.)--MA 15

## SURGERY

23.1 - The cost of care before and after the surgery or procedure is included in the approved amount for that service.--CO B15

23.2 - Cosmetic surgery and related services are not covered.--PR 48

23.3 - Medicare does not pay for surgical supports except primary dressings for skin grafts.--CO 97

23.4 - A separate charge is not allowed because this service is part of the major surgical procedure.--CO 97

23.5 - Payment has been reduced because a different doctor took care of you before and/or after the surgery.--CO B20

23.6 - This surgery was reduced because it was performed with another surgery on the same day.--CO 59

23.7 - Payment cannot be made for an assistant surgeon in a teaching hospital unless a resident doctor was not available.--CO B6

23.8 - This service is not payable because it is part of the total maternity care charge.--CO 97

23.9 - Payment has been reduced because the charges billed did not include post-operative care. --CO B20

23.10 -Payment has been reduced because this procedure was terminated before anesthesia was started.--CO 115

23.11 -Payment cannot be made because the surgery was canceled or postponed.--CO 115

23.12 -Payment has been reduced because the surgery was canceled after you were prepared for surgery.--CO 115

23.13 -Because you were prepared for surgery and anesthesia was started, full payment is being made even though the surgery was canceled.--This would be reflected by showing the full billed amount in the allowed amount on the RA, not through a separate message.

23.14 -The assistant surgeon must file a separate claim for this service.--CO B20 with MA12

23.15 -The approved amount is less because the payment is divided between two doctors. (NOTE: use for global reductions.)--CO B20

23.16- An additional amount is not allowed for this service when it is performed on both the left and right sides of the body.--CO 42

**FRAUD AND ABUSE SECTION (HELP STOP FRAUD)**

24.1 - Protect your Medicare number as you would a credit card number.--MSN only, not RA

24.2 - Beware of telemarketers or advertisements offering free or discounted Medicare items and services.--MSN only

24.3 - Beware of door-to-door solicitors offering free or discounted Medicare items or services. --MSN only

24.4 - Only your physician can order medical equipment for you.--If used to deny an item, CO B6 on RA; if used as information only, would only appear on MSN.

24.5 - Always review your Medicare Summary Notice for correct information about the items or services you received.--MSN only

24.6 - Do not sell your Medicare number or Medicare Summary Notice.--MSN only

24.7 - Do not accept free medical equipment you don't need.--MSN only

24.8 - Beware of advertisements that read, "This item is approved by Medicare", or "No out-of-pocket expenses."--MSN only

24.9 - Be informed - Read your Medicare Summary Notice.--MSN only

24.10 -Always read the front and back of your Medicare Summary Notice.--MSN only

24.11 -Beware of Medicare scams, such as offers of free milk or cheese for your Medicare number.--MSN only

24.12 -Read your Medicare Summary Notice carefully for accuracy of dates, services, and amounts billed to Medicare.--MSN only

24.13 -Be sure you understand anything you are asked to sign.--MSN only

24.14 -Be sure any equipment or services you received were ordered by your doctor.--MSN only

**TIME LIMIT FOR FILING**

25.1 - This claim was denied because it was filed after the time limit.--CO 29

25.2 - You can be billed only 20 percent of the charges that would have been approved.--PR group code with coinsurance reason code (2) on ERA or entry in dedicated coinsurance column on paper RA.

**VISION**

26.1 - Eye refractions are not covered.--PR 48

26.2 - Eyeglasses or contact lenses are only covered after cataract surgery or if the natural lens of your eye is missing.--PR 48

26.3 - Only one pair of eyeglasses or contact lenses is covered after cataract surgery with lens implant.--CO 57

26.4 - This service is not covered when performed by this provider.--B7

26.5 - This service is covered only in conjunction with cataract surgery.--CO 107

26.6 - Payment was reduced because the service was terminated early.--CO 115

**HOSPICE**

27.1 - This service is not covered because you are enrolled in a hospice.--B9

27.2 Medicare will not pay for inpatient respite care when it exceeds five (5) consecutive days at a time.--PR 119

27.3 The physician certification requesting hospice services was not received timely.--B17 with MA54

27.4 The documentation received indicates that the general inpatient services were not related to the terminal illness. Therefore, payment will be adjusted to the routine home care rate. --CO 58

27.5 Payment for the day of discharge from the hospital will be made to the hospice agency at the routine home care rate.--This would be shown on the RA to the hospice by payment for that date as billed by the hospice. No separate message would be needed. The payment rate would be shown as the allowed amount.

27.6 The documentation indicates the level of care was at the respite level not the general inpatient level of care. Therefore, payment will be adjusted to the routine home care rate. --57 (the level of care being paid would be indicated by the allowed amount)

27.7 According to Medicare hospice requirements, the hospice election consent was not signed timely.--106 with MA54

27.8 The documentation submitted does not support that your illness is terminal.--57 with zero payment for hospice.

27.9 The documentation indicates your inpatient level of care was not reasonable and necessary. Therefore, payment will be adjusted to the routine home care rate.--57 (the level of care being paid would be indicated by the allowed amount)

27.10 The documentation indicates that the level of continuous care was not reasonable and necessary. Therefore, payment will be adjusted to the routine home care rate.--57 (the level of care being paid would be indicated by the allowed amount)

27.11 The provider has billed in error for the routine home care items or services received.--CO 97

**MANDATORY ASSIGNMENT FOR PHYSICIAN SERVICES FURNISHED FOR MEDICAID PATIENTS**

28.1 - Because you have Medicaid, your provider must agree to accept assignment.--111

**MSP**

29.1 - Secondary payment cannot be made because the primary insurer information was either missing or incomplete.--CO 16 with MA04

29.2 - No payment was made because your primary insurer's payment satisfied the provider's bill.--CO 23

29.3 - Medicare benefits are reduced because some of these expenses have been paid by your primary insurer.--CO 23

29.4 - In the future, if you send claims to Medicare for secondary payment, please send them to (carrier MSP address).--MSN only

29.5 - Our records show that Medicare is your secondary payer. This claim must be sent to your primary insurer first. (NOTE: Use 'Add-on' message as appropriate).--CO 22

29.6 - Our records show that Medicare is your secondary payer. Services provided outside your prepaid health plan are not covered. We will pay this time only since you were not previously notified.--MA11

29.7 - Medicare cannot pay for this service because it was furnished by a provider who is not a member of your employer prepaid health plan. Our records show that you were informed of this rule.--PR 24 with MA26

29.8 - This claim is denied because the service(s) may be covered by the worker's compensation plan. Ask your provider to submit a claim to that plan.--19

29.9 - Since your primary insurance benefits have been exhausted, Medicare will be primary on this accident related service.--This would be indicated on the RA by Medicare payment at the primary rate without MSP offset. No separate message.

29.10 -These services cannot be paid because you received them on or before you received a liability insurance payment for this injury or illness.--PR 20

29.11 -Our records show that an automobile medical, liability, or no-fault insurance plan is primary for these services. Submit this claim to the primary payer. (NOTE: Use 'Add-on' message as appropriate).--20 if liability, 21 if no fault or 22 if medical is primary

29.12 -Our records show that these services may be covered under the Black Lung Program. Contact the Federal Black Lung Program, P.O. Box 828, Lanham-Seabrook, MD 20703-0828. (NOTE: Use 'Add-on' message as appropriate).--CO 22 with MA16

29.13 Medicare does not pay for these services because they are payable by another government agency. Submit this claim to that agency. (NOTE: Use 'Add-on' message as appropriate).--CO 22

29.14 -Medicare's secondary payment is ( $ ). This is the difference between the primary insurer's approved amount of ( $ ) and the primary insurer's paid amount of ( $ ). (NOTE: Mandated message - This message should print claim level when a Medicare secondary payment is made and the primary insurer's approved amount is higher than Medicare's approved amount. Do not print when the claim paid amount is equal to the amount Medicare would pay if services were not covered by a third party payer.)--The fact that the Medicare payment is secondary is reflected by reference to the primary's payment with group OA and claim adjustment reason code 71.

29.15 - Medicare's secondary payment is ( $ ). This is the difference between Medicare's approved amount of ( $ ) and the primary insurer's paid amount of ( $ ). (NOTE: Mandated message - This message should print claim level when a Medicare secondary payment is made and Medicare's approved amount is higher than the primary insurer's approved amount. Do not print when the claim paid amount is equal to the amount Medicare would pay if services were not covered by a third party payer.) -- The fact that the Medicare payment is secondary is reflected by reference to the primary's payment with

group OA and claim adjustment reason code 71.

29.16 -Your primary insurer approved and paid ( $ ) on this claim. Therefore, no secondary payment will be made by Medicare. (NOTE: Mandated message - This message should print claim or service level when the primary insurer's approved amount is higher than Medicare's approved amount and the primary payment is equal to the approved amount. Do not print on denied service lines.) --Would be shown on RA with OA 71 amount entry and 0 Medicare payment.

29.17 -Your provider agreed to accept ( $ ) as payment in full on this claim. Your primary insurer has already paid ( $ ) so Medicare's payment is the difference between the two amounts. (NOTE: Mandated message - This message should print claim level when the provider is obligated to accept less than the Medicare approved amount.)--If the provider has agreed to accept a lower than normal amount, that lower rate would be shown as the allowed amount on the provider's RA. The Medicare payment column would show the difference between this allowed amount and the OA 71 entry.

29.18 -The amount listed in the 'You May Be Billed' column assumes that your primary insurer paid the provider. If your primary insurer paid you, then you are responsible to pay the provider the amount your primary insurer paid to you plus the amount in the 'You May Be Billed' column. (NOTE: Mandated message - This message should print on all assigned MSP service lines when Medicare secondary payment was made. Print message on assigned service lines for full recoveries. Do not print on denied service lines.)-- If Medicare is notified of a primary insurer's payment, the amount of that payment that affects the calculation of what is due from Medicare would be reported on the RA. The group code would designate the amount(s) for which the provider could (PR), or could not (CO) bill the beneficiary. The RA would also show the total due from the patient for all services in the claim in the CLP 05 segment of an intermediary RA.

29.19 -The amount listed in the 'You May Be Billed' column assumes that your primary insurer paid you. If your primary insurer paid the provider, then you only need to pay the provider the difference between the amount charged and the amount the primary insurer paid. (NOTE: Mandated message - This message should print on all unassigned MSP service lines when Medicare secondary payment was made. Print message on unassigned service lines for full recoveries. Do not print on denied service lines. Do not print when conditions in 29.20 or 29.22 are met.)--Same as 29.18 response for RA.

29.20 -The amount listed in the 'You May Be Billed' column assumes that your primary insurer paid you. If your primary insurer paid the provider, then you only need to pay the provider the difference between the amount the provider agreed to accept and the amount the primary insurer paid. (NOTE: This message should print on all unassigned MSP service lines when the provider is obligated to accept less than the Medicare approved amount. Do not print on denied service lines.)--Same as 29.18 response for RA.

29.21 -The amount listed in the 'You May Be Billed' column assumes that your primary insurer made no payment for this service. If your primary insurer did make payment for this service, the amount you may be billed is the difference between the amount charged and the primary insurer's payment. (NOTE: Mandated message - This message should print on all Medicare disallowed services for which the beneficiary is liable and the service has been submitted on a claim indicating there has been a primary insurer payment made.)--Same as 29.18 for response for RA. May also need to use MA 11 if payment made on a conditional basis and later payment may be issued by another payer.

29.22 -The amount listed in the 'You May Be Billed' column assumes that your primary insurer paid you. If your primary insurer paid the provider, then you only need to pay the provider the difference between the amount the provider can legally charge and the amount the primary insurer paid. See note ( ) for the legal charge limit. (NOTE: This message should print on all unassigned MSP service lines when a Medicare secondary payment is made and the provider has exceeded the limiting charge.)--Same as 29.18 response for patient billing information. An excess limiting charge amount that could not be billed to the beneficiary would be shown with a CO 45 adjustment.

29.23 -No payment can be made because payment was already made by either worker's compensation or the Federal Black Lung Program.--CO 19

29.24 - No payment can be made because payment was already made by another government entity.--CO 23

29.25 - Medicare paid all covered services not paid by other insurer.-- RA would show Medicare payment which equals the difference between the billed amount and the adjustments.

29.26 -The primary payer is ___ . (NOTE: Add-on to messages as appropriate and/or as your system permits.)--Not reported in any pre-4010 X12.835 version or any NSF/RA version..

29.27 -Your primary group's payment satisfied Medicare deductible and co-insurance.--Shown on RA with A3 adjustment amount corresponding to the deductible, coinsurance, and/or any other PR group adjustments, or by not showing any deductible and coinsurance amounts to be satisfied.

29.28 -Your responsibility on this claim has been reduced by the amount paid by your primary insurer.--Reflect by use of an A3 adjustment reason code on a RA.

29.29 -Your provider is allowed to collect a total of ( $ ) on this claim. Your primary insurer paid ( $ ) and Medicare paid ( $ ). You are responsible for the unpaid portion of ( $ ).--Shown in NSF/RA 500-23 or 835 2-010-CLP05

29.30 -( $ ) of the money approved by your primary insurer has been credited to your Medicare Part B (A) deductible. You do not have to pay this amount.--Shown on RA with A3 adjustment amount corresponding to the deductible, coinsurance, and/or any other PR group adjustments, or by not showing any deductible and coinsurance amounts to be satisfied.

29.31 Resubmit this claim with the missing or correct information.--MA 130

## REASONABLE CHARGE AND FEE SCHEDULE

30.1 -The approved amount is based on a special payment method.--CO 42

30.2 -The facility fee allowance is greater than the billed amount.--OA 94

30.3 -Your doctor did not accept assignment for this service. Under Federal law, your doctor cannot charge more than ( $ ). If you have already paid more than this amount, you are entitled to a refund from the provider. (NOTE: This message should print on all unassigned service lines for which the billed amount exceeds the Medicare limiting charge. Do not print when the amount the limiting charge is exceeded is less than any threshold established by HCFA.)--CO 45 with adjustment amount in excess of the limiting charge; PR42 with the amount that is the difference between the allowed amount and the limiting charge for which the beneficiary is liable; if excess payment made by the beneficiary, Also report MA77 or MA78 as applicable for the provider to refund the excess to the beneficiary.

30.4 - A change in payment methods has resulted in a reduced or zero payment for this procedure.--CO 42

## ADJUSTMENTS

NOTE: You must print at least one of the messages in this section for all adjusted claims shown on the MSN.

31.1 - This is a correction to a previously processed claim and/or deductible record.--Reflected with CR group and full correction/reversal, or with alternate correction method (CLP 02-22 reversal) or MA 67 on a paper RA correction.

31.2 - A payment adjustment was made based on a telephone review.--MA 62 with the adjustment data.

31.3 - This notice is being sent to you as the result of a reopening request.--MA 91 (generic appeal decision message)

31.4 - This notice is being sent to you as the result of a fair hearing request.--MA 91

31.5 - If you do not agree with the Medicare approved amount(s) and $100 or more is in dispute (less deductible and co-insurance), you may ask for a hearing. You must request a hearing within 6 months of the date of this notice. To meet the limit you may combine amounts on other claims that have been reviewed. At the hearing, you may present any new evidence which could affect the decision. Call us at the number in the Customer Service block if you need more information about the hearing process.--MA 03

31.6 - A payment adjustment was made based on a Peer Review Organization request.--Source of adjustment requests is not reported on RAs.

31.7 - This claim was previously processed under an incorrect Medicare claim number or name. Our records have been corrected.--CR, CLP 22 or MA 67 for basic adjustment as per 31.1 with the corrected name /# information reported elsewhere in assigned RA field.

31.8 - This claim was adjusted to reflect the correct provider.--CR, CLP 22 as MA 67 with corrected provider data elsewhere in the RA.

31.9 - This claim was adjusted because there was an error in billing.--Generic adjustment indicator (CR, CLP 22 or MA 67 as appropriate) with correction data.

31.10 -This is an adjustment to a previously processed charge (s). This notice may not reflect the charges as they were originally submitted.--Would be reflected in a CLP 22 adjustment by a carrier using the alternate reversal method to report differences rather a full reversal and correction.

31.11 -The previous notice we sent stated that your doctor could not charge more than ( $ ). This additional payment allows your doctor to bill you the full amount charged. (NOTE: Mandated message - This message should print service level, as appropriate, when limiting charge applies.)--This would be shown as a correction/reversal action on a RA with the new amount for which the patient is liable reported with the PR group code.

31.12 -The previous notice we sent stated the amount you could be charged for this service. This additional payment changed that amount. Your doctor cannot charge you more than ( $ ). (NOTE: Mandated message - This message should print service level, as appropriate, when limiting charge applies.)--31.11 response also applies here.

31.13 -The Medicare paid amount has been reduced by ( $ ) previously paid for this claim. (NOTE: Mandated message - This message should print claim level on all adjustments for which a partial payment was previously made.)--Would be shown as a correction/reversal action on an RA, with the amount of the previous payment reported with a B13 claim adjustment reason code and the amount of the prior payment.

31.14 -This payment is the result of an Administrative Law Judge's decision.--MA 91
(RA's do not differentiate between levels of appeals. An ALJ would send out a separate decision notice. The remittance would only be used if a payment is being made as result of that decision.)

31.15 -An adjustment was made based on a review decision.--MA91

31.16 -An adjustment was made based on a reconsideration.--MA91

## OVERPAYMENTS/OFFSETS

32.1 - ($) dollars of this payment has been withheld to recover a previous overpayment. (NOTE: Mandated message - This message should print claim level when the beneficiary check amount is reduced to recover a previous overpayment. Fill in the blank with the amount withheld on the claim at issue.)--Overpayment withholding from a beneficiary would not be reported on a RA. A RA would only show funds recouped to satisfy an overpayment to the provider. In that case, provider level adjustment code OR (overpayment recovery) would be used by an intermediary and code OF(offset) would be used by a carrier.

## AMBULATORY SURGICAL CARE

33.1 - The ambulatory surgical center must bill for this service.--CO B6 with M 97

## PATIENT PAID / SPLIT PAYMENT

34.1 - Of the total ( $ ) paid on this claim, we are paying you ( $ ) because you paid your provider more than your 20 percent co-insurance on Medicare approved services. The remaining ( $ ) was paid to the provider. (NOTE: Mandated message - This message should print claim level on all assigned claims generating payment to the beneficiary.)--Amount paid to beneficiary would be reported with CO100 on RA; a separate payment amount would be reported for the provider, and a provider level OF or OR entry (see 32.1) would be made for the amount in excess of 20% Medicare refunded to the beneficiary.

34.2 - The amount in the 'You May Be Billed' column has been reduced by the amount you paid the provider at the time the services were rendered. (NOTE: Mandated message - This message should print claim level on all assigned claims with a beneficiary paid amount that does not exceed co-insurance and deductible and for all unassigned claims submitted with a beneficiary paid amount.)--Report the patient paid data in AMT 01/02 and the total of the PR adjustments on the RA in CLP05. Use MA59 to notify the provider a refund must be issued the beneficiary if AMT02 is higher than the PR total.

34.3 - After applying Medicare guidelines and the amount you paid to the provider at the time the services were rendered, our records indicate you are entitled to a refund. Please contact your provider. (NOTE: Mandated message: This message should print claim level on assigned claims with a split payment to the beneficiary under $1.00)--MA 78

34.4 - We are paying you ($) because the amount you paid the provider was more than you may be billed for Medicare approved charges.--OA 100 with payment amount to the beneficiary; prior payment information by patient to provider in AMT 01/02; and amount of patient responsibility for the claim in CLP 05.

34.5 - The amount owed you is ($). Medicare does not routinely issue checks for amounts under $1.00. This amount due will be included in your next check. If you want this money issued immediately, please contact us at the address or phone number in the Customer Service Information Box.--MA 22

34.6 - Your check includes ____ which was withheld on a prior claim.--A reissuance of funds to a beneficiary would not be reported to a provider.

34.7 - This check includes an amount less than $1.00 which was withheld on a prior claim. (NOTE: Use this message only when your system cannot plug the dollar amount in message 34.6.)--BF provider level adjustment with MA 22.

34.8 - The amount you paid the provider for this claim was more than the required payment. You should be receiving a refund of $.XX from your provider, which is the difference between what you paid and what you should have paid. (NOTE: Mandated message: This message should print claim level on assigned claims with a split payment to the beneficiary under $1.00)--MA 78

## SUPPLEMENTAL COVERAGE / MEDIGAP

35.1 - This information is being sent to your private insurer(s). Send any questions regarding your benefits to them. (NOTE: add if possible : Your private insurer(s) is/are ____ .)--MA 18 with private insurer identified in NM103

35.2 - We have sent your claim to your Medigap insurer. Send any questions regarding your benefits to them. (NOTE: add if possible: Your Medigap insurer is ____.)--MA 18 with private insurer identified in NM103

35.3 - A copy of this notice will not be forwarded to your Medigap insurer because the information was incomplete or invalid. Please submit a copy of this notice to your Medigap insurer.--MA 19

35.4 - A copy of this notice will not be forwarded to your Medigap insurer because your provider does not participate in the Medicare program. Please submit a copy of this notice to your Medigap insurer.--MA 08

35.5 - We did not send this claim to your private insurer. They have indicated no additional payment can be made. Send any questions regarding your benefits to them.--This would be expressed on a RA by the absence of transfer information.

35.6 - Your supplemental policy is not a Medigap policy under Federal and State law/regulation. It is your responsibility to file a claim directly with your insurer.--MA 08

35.7 - Please do not submit this notice to them.(add-on to other messages as appropriate)--This message would not be used on an RA.

**LIMITATION OF LIABILITY**

36.1 - Our records show that you were informed in writing, before receiving the service, that Medicare would not pay. You are liable for this charge. If you do not agree with this statement, you may ask for a review.--M38

36.2 - It appears that you did not know that we would not pay for this service, so you are not liable. Do not pay your provider for this service. If you have paid your provider for this service, you should submit to this office three things: 1) a copy of this notice, 2) your provider's bill and, 3) a receipt or proof that you have paid the bill. You must file your written request for payment within 6 months of the date of this notice. Future services of this type provided to you will be your responsibility.--M 25

36.3 - Your provider has been notified that you are due a refund if you paid for this service. If you do not receive a refund from the provider within 30 days from your receipt of this notice, please write our office and include a copy of this notice. Your provider has the right to appeal this decision, which may change your right to a refund.--M 26

36.4 - This payment refunds the full amount you paid to your provider for the services previously processed and denied. You are entitled to this refund because your provider did not tell you in writing before providing the service(s) that Medicare would not pay for the denied service (s). In the future, you will have to pay for this service when it is denied.--An overpayment notice, rather than an RA would be sent to the provider in this situation.

36.5 - This payment refunds the full amount you are entitled to for services previously processed and reduced. You are entitled to this refund because your provider did not tell you in writing before providing the service (s) that Medicare would approve it at a lower amount. In the future, you will have to pay for the service as billed when it is reduced.--Issued to beneficiary when provider fails to refund and overpayment action is taken against

provider. Not a RA situation.

36.6 - Medicare is paying this claim, this time only, because it appears that neither you nor the provider knew that the service(s) would be denied. Future services of this type provided to you will be your responsibility.--M17

**DEDUCTIBLE / COINSURANCE**

Print the following messages in the Notes Section as appropriate.

37.1 - This approved amount has been applied toward your deductible. (NOTE: Mandated message - This message should print on each service line with the total approved amount applied to the deductible.)--Would be shown with a deductible amount on the RA that equaled the allowed amount and a 0 payment for the service.

37.2 - ($) of this approved amount has been applied toward your deductible. (NOTE: Mandated message - This message should print on each service line with a portion of the approved amount applied to the deductible.)--The RA would show the amount of the deductible used to calculate the payment.

37.3 - ( ) was applied to your inpatient deductible. (NOTE: Mandated message - This message should print on all Part A line items with all, or a portion of the approved amount applied to the inpatient deductible.)--Same as 37.2 response.

37.4 - ( ) was applied to your inpatient coinsurance.--Would be reflected with an amount entry in the coinsurance field or as PR 2 on an RA.

37.5 - ( ) was applied to your skilled nursing facility coinsurance.--RA does not differentiate between types of coinsurance, would be handled the same as with 37.4

37.6 - ( ) was applied to your blood deductible.--PR 66

37.7 - Part B cash deductible does not apply to these services.--Would be reflected by the lack of a deductible change on the RA.

37.8 - Coinsurance amount includes outpatient mental health treatment limitation.--PR 122 (psychiatric reduction) is reported separately from the 20% coinsurance on an RA as the psychiatric reduction is not technically a form of coinsurance.

Print the following messages in the 'Deductible Information Section' as appropriate. Print a message for each different type of deductible situation displayed on the MSN. Do not print more than one type of deductible message for each year represented on the MSN (e.g., do not print both 37.9 and 37.11 on the same MSN.)

37.9 - You have now met ( $ ) of your ( $ ) Part B deductible for (year ).--This total not provided on RA.

37.10- You have now met ( $) of your ( $ ) Part A deductible for this benefit period.--This total is not reported on a RA.

37.11- You have met the Part B deductible for (year).--Would be reflected on RA by lack of reduction in payment for a Part B deductible.

37.12- You have met the Part A deductible for this benefit period.--As with 37.11

37.13- You have met the blood deductible for (year).--As with 37.11

37.14- You have met ( ) pint(s) of your blood deductible for (year).--This total not provided on RA

## GENERAL INFORMATION SECTION

38.1 - If you think Medicare was billed for something you did not receive, please call our Fraud Hotline, (phone number of Fraud Hotline).--Not sent on RA

38.2 - If you were offered free items or services but Medicare was billed, please call our Fraud Hotline, (phone number of Fraud Hotline)--Not sent on RA

38.3 - If you change your address, please contact (contractor name) by calling (contractor phone) and the Social Security Administration by calling 1-800-772-1213.--Not sent on RA

## HOME HEALTH MESSAGES (Section 41)

41.1 Medicare will only pay for this service when it is provided in addition to other services.--PR 107

41.2 This service must be performed by a nurse with the required psychiatric nurse credentials. --CO B6

41.3 The medical information did not support the need for continued services.--CO 57

41.4 This item is not considered by Medicare to be appropriate for home use.--CO 58

41.5 Medicare does not pay for comfort or convenience items.--PR 46

41.6 This item was not furnished under a plan of care established by your physician--PR D14

41.7 This item is not considered by Medicare to be a prosthetic and/or orthotic device.--CO 46

41.8 Based on the information provided, your illness or injury did not prevent you from leaving your home unaided.--PR 58

41.9 Services exceeded those ordered by your physician.--CO 57

41.10 Patients eligible to receive home health benefits from another government agency are not eligible to receive Medicare benefits for the same service.--OA 22

41.11 Doctors orders were incomplete.--CO B17

41.12 The Provider has billed in error for items/services according to the medical record.--CO B12

41.13 The Provider has billed for services/items not documented in your record.--CO B12

41.14 This service/item was billed incorrectly.--Would be reflected on an RA as a post adjudication adjustment

41.15 The information shows that you can do your own personal care.--PR 50

41.16 To receive Medicare payment, you must have a signed doctor's order before you receive the services.--CO B17

**"Add-on" Messages - Section 39**

9.3 - Please ask your provider to submit a new complete claim to us. (NOTE: Add-on to other messages as appropriate.)--MA 130

9.7 - We have asked your provider to resubmit the claim with the missing or correct information. (NOTE: Add-on to other messages as appropriate.)--MA 130

15.16 -Your claim was reviewed by our Medicare staff. (NOTE: Add-on to other messages as appropriate.)--Result of the review but not the fact of the review would be reported on an RA.

15.17 - We have approved this service at a reduced level. (NOTE: Add-on to other messages as appropriate.)--Would be conveyed by a payment amount of less than the billed amount on an RA, not by an explicit message. The reason for the reduction would be shown with the appropriate claim adjustment reason code.

16.34- You should not be billed for this item or service. You do not have to pay this amount. (Add-on to other messages, or use individually as appropriate.)--Would be reflected by use of the CO group code on an RA.

16.35- You do not have to pay this amount. (NOTE: Add-on to other messages as appropriate.)--CO group code with the claim adjustment reason code and amount

16.36- If you have already paid it, you are entitled to a refund from this provider. (NOTE: Add-on to other messages as appropriate.)--M26 or MA72, depending on whether a line level or claim level message is needed

16.37 -Please see the back of this notice. (NOTE: Add-on to other messages as you feel appropriate.)--Does not apply to a RA

16.45 -You cannot be billed separately for this item or service. You do not have to pay this amount.--CO group code on RA

25.2 - You can be billed only 20 percent of the charges that would have been approved. (NOTE: Add-on to 25.1 for assigned claims.)--PR group code with the coinsurance entry (reason code 2 or entry in dedicated coinsurance column on paper RA)

29.26 -The primary payer is ___ . (NOTE: Add-on to messages as appropriate and/or as your system permits.)--Not reported in any pre-4010 X12.835 version or any NSF/RA version.. Would only be reported on a RA where a crossover agreement applied with the primary payer.

29.31 Resubmit this claim with the missing or correct information.--MA130

35.7 - Please do not submit this notice to them. (add-on to other messages as appropriate)--This message would not be used on a RA.

**Mandated Messages - Section 40**

14.7 - This service is paid at 100% of the Medicare approved amount. (NOTE: Mandated message - This message must appear on all service lines paid at 100% of the Medicare approved amount.)--Would be reflected on RA by payment amount which equals the shown allowed amount, not by a separate message

16.11 -Payment was reduced for late filing. You cannot be billed for the reduction. (NOTE : Mandated message - This message must print on all service lines subject to the 10% reduction.)--Since a late filing reduction is applied to a provider rather than a beneficiary, a late filing reduction is reported as a provider level adjustment on a RA with a LF adjustment code.

16.12 -Outpatient mental health services are paid at 50 percent of the approved charges. (NOTE: Mandated message - This message must print on all service lines subject to the outpatient psychiatric reduction.)--PR122

16.33 -Your payment includes interest because Medicare exceeded processing time limits.(NOTE: Mandated message - This message must print claim level if interest is added into the beneficiary payment amount for unassigned or split pay claims.) .--Interest paid to a beneficiary would not be reported on the RA sent to the provider. Interest paid a provider would be reported on a RA with an IN (interest) adjustment reason code at the provider level.

20.4 - ( ) of the Benefit Days Used were charged to your Lifetime Reserve Day benefit. (NOTE: Mandated message - This message must be printed claim level when all or a portion of the Benefit Days Used are charged to the Lifetime Reserve Day benefit.)--Would be shown with a LA qualifier in the QTY segment of a RA

22.1 - Your claim was separated for processing. The remaining services may appear on a separate notice. (NOTE: Mandated message - This message must print claim level on all split claims, including the original and replicate claim.)--MA15

29.14 - Medicare's secondary payment is ( $ ). This is the difference between the primary insurer's approved amount of ( $ ) and the primary insurer's paid amount of ( $ ). (NOTE: Mandated message - This message should print claim level when a Medicare secondary payment is made and the primary insurer's approved amount is higher than Medicare's approved amount. Do not print when the claim paid amount is the amount Medicare would pay if services were not covered by a third party insurer.)--The fact that a Medicare payment is secondary is reflected by reference to the primary's payment with group OA and claim adjustment reason code 71 on a RA.

29.15 - Medicare's secondary payment is ( $ ). This is the difference between Medicare's approved amount of ( $ ) and the primary insurer's paid amount of ( $ ). (NOTE: Mandated message - This message should print claim level when a Medicare secondary payment is made and Medicare's approved amount is higher than the primary insurer's approved amount. Do not print when the claim paid amount is equal to the amount Medicare would pay if services were not covered by a third party payer.)--Same as 29.14

29.16 -Your primary insurer approved and paid ( $ ) on this claim. Therefore, no secondary payment will be made by Medicare. (NOTE: Mandated message - This message should print claim or service level when the primary insurer's approved amount is higher than Medicare's approved amount and the primary payment is equal to the approved amount. Do not print on denied service lines.)--Would be shown on RA with OA71 entry and 0 Medicare payment.

29.17 -Your provider agreed to accept ( $ ) as payment in full on this claim. Your primary insurer has already paid ( $ ) so Medicare's payment is the difference between the two amounts. (NOTE: Mandated message - This message should print claim level when the provider is obligated to accept less than the Medicare approved amount.)--If the provider has agreed to accept a lower than normal amount, that lower rate would be shown as the allowed amount on the provider's RA. The Medicare payment column/data element would shown the difference between this allowed amount and the OA71 entry.

29.18 -The amount listed in the 'You May Be Billed' column assumes that your primary insurer paid the provider. If your primary insurer paid you, then you are responsible to pay the provider the amount your primary insurer paid to you plus the amount in the 'You May Be Billed' column. (NOTE: Mandated message - This message should print on all assigned MSP service lines when Medicare secondary payment was made. Print message on assigned service lines for full recoveries. Do not print on denied service lines.)--If Medicare is notified of the amount of a primary insurer's payment, the amount of that payment that affects the calculation of what is due from Medicare would be reported on the RA. The group code would designate the amount(s) for which the provider could, or could not, bill the beneficiary. The electronic and carrier paper RA would also show the total due from the patient for all services in the CLP05 data element.

29.19 -The amount listed in the 'You May Be Billed' column assumes that your primary insurer paid you. If your primary insurer paid the provider, then you only need to pay the provider the difference between the amount charged and the amount the primary insurer paid. (NOTE: Mandated message - This message should print on all unassigned MSP service lines when Medicare secondary payment was made. Print message on unassigned service lines for full recoveries. Do not print on denied service lines. Do not print when conditions in 29.20 or 29.22 are met.)--Same as 29.18

29.20 -The amount listed in the 'You May Be Billed' column assumes that your primary insurer paid you. If your primary insurer paid the provider, then you only need to pay the provider the difference between the amount the provider agreed to accept and the amount the primary insurer paid. (NOTE: This message should print on all unassigned MSP service lines when the provider is obligated to accept less than the Medicare approved amount. Do not print on denied service lines.)--Same as 29.18

29.21 -The amount listed in the 'You May Be Billed' column assumes that your primary insurer made no payment for this service. If your primary insurer did make payment for this service, the amount you may be billed is the difference between the amount charged and the primary insurer's payment. (NOTE: Mandated message - This message should print on all Medicare disallowed services for which the beneficiary is liable and the service has been submitted on a claim indicating there has been a primary insurer payment made.)--See 29.18 RA response. There may also be a need to use the MA11 remark code if payment is made on a conditional basis as a future payment may be issued by another payer.

29.22 -The amount listed in the 'You May Be Billed' column assumes that your primary insurer paid you. If your primary insurer paid the provider, then you only need to pay the provider the difference between the amount the provider can legally charge and the amount the primary insurer paid. See note ( ) for the legal charge limit. (NOTE: This message should print on all unassigned MSP service lines when a Medicare secondary payment is made and the provider has exceeded the limiting charge.)--See 29.18 information for patient billing information. An excess limiting charge amount that could be billed to a beneficiary would be shown with CO45 and the excess amount.

30.3 - Your doctor did not accept assignment for this service. Under Federal law, your doctor cannot charge more than ( $ ). If you have already paid more than this amount, you are entitled to a refund from the provider. (NOTE: This message should print on all assigned service lines for which the billed amount exceeds the Medicare limiting charge. Do not print when the amount the limiting charge is exceeded is less than any threshold established by HCFA.)--MA77 or MA78 as applicable

34.3 - After applying Medicare guidelines and the amount you paid to the provider at the time the services were rendered, our records indicate you are entitled to a refund Please contact your provider. (NOTE: Mandated message: This message should print on assigned claims with a split payment to the beneficiary under $1.00)--MA78

31.11 -The previous notice we sent stated that your doctor could not charge more than ( $ ). This additional payment allows your doctor to bill you the full amount charged. (NOTE: Mandated message - This message should print claim level, as appropriate, when limiting charge applies.)--This would be shown as a correction/reversal action on a RA, with the amount for which the patient is liable reported with the PR group and the applicable reason code.

31.12 -The previous notice we sent stated the amount you could be charged for this service. This additional payment changed that amount. Your doctor cannot charge you more than ( $ ). (NOTE: Mandated message - This message should print claim level, as appropriate, when limiting charge applies.)--Same as 31.11

31.13 -The Medicare paid amount has been reduced by ( $ ) previously paid for this claim. (NOTE: Mandated message - This messages should printed claim level on all adjustments for which a partial payment was previously made.)--Would be shown as a correction/reversal action on a RA, with the amount of the previous payment reported with OA B13 and the amount of the prior payment.

32.1 - ($) dollars of this payment has been withheld to recover a previous overpayment. (NOTE: Mandated message - This message should print claim level when the beneficiary check amount is reduced to recover a previous overpayment. Fill in the blank with the amount withheld on the claim at issue.)--Would be shown on RA only if the money is being withheld for an overpayment to the provider. Provider level adjustment code OR, overpayment recovery, would be used by an intermediary, or OF, offset, would be used by a carrier.

34.1 - Of the total ( $ ) paid on this claim, we are paying you ( $ ) because you paid your provider more than your 20 percent co-insurance on Medicare approved services. The remaining ( $ ) was paid to the provider. (NOTE: Mandated message - This message should print claim level on all assigned split pay claims.)--The amount paid to the beneficiary would be reported on a RA with CO100. The amount being withheld from the provider to recoup the overpayment by the beneficiary would be reported by a carrier with an OR provider level recovery adjustment on the RA.

34.2 - The amount in the 'You May Be Billed' column has been reduced by the amount you paid the provider at the time the services were rendered. (NOTE: Mandated message - This message should print claim level on all assigned claims with a beneficiary paid amount that does not exceed co-insurance and deductible and for all unassigned claims submitted with a beneficiary paid amount.)--On a carrier RA, the patient responsibility field on a paper RA or the CLP05/NSF500-23 field on an ERA should be adjusted to show the net of the full patient liability less the amount already paid by the patient. This is also in CLP05 of the intermediary ERA but is not reported on the intermediary paper RA.

34.3 - After applying Medicare guidelines and the amount you paid to the provider at the time the services were rendered, our records indicate you are entitled to a refund. Please contact your provider. (NOTE: Mandated message: This message should print claim level on assigned claims with a split payment to the beneficiary under $1.00)--MA78

34.8 - The amount you paid the provider for this claim was more than the required payment. You should be receiving a refund of $.XX from your provider, which is the difference between what you paid and what you should have paid. (NOTE: Mandated message: This message should print claim level on assigned claims with a split payment to the beneficiary under $1.00)--MA78

37.1 - This approved amount has been applied toward your deductible. (NOTE: Mandated message - This message should print on each service line with the total approved amount applied to the deductible.)--Would be shown with a deductible amount on the RA that equaled the allowed amount and a 0 payment for the service.

37.2 - A portion of this approved amount has been applied toward your deductible. (NOTE: Mandated message - This messages should print on each service line with a portion of the approved amount applied to the deductible.)--The RA would show the amount of the deductible used to calculate the payment.

37.3 - ( ) was applied to your inpatient deductible. (NOTE: Mandated message - This message should print on all Part A line items with all, or a portion of the approved amount applied to the inpatient deductible.)--Same as 37.2

Print the following messages in the 'Deductible Information Section' of the MSN as appropriate. Print all messages that apply. There must be at least one message printed in the Deductible Section for all MSNs.--*The following messages do not apply to RAs.*

37.9 - You have now met ( $ ) of your ( $ ) Part B deductible for (year ).

37.10 -You have now met ( $) of your ( $ ) Part A deductible for this benefit period.

37.11 -You have met the Part B deductible for (year).

37.12 -You have met the Part A deductible for this benefit period.

37.13 -You have met the blood deductible for (year).

37.14 -You have met ( ) pints of your blood deductible.

**Demonstration Project**

60.1 In partnership with physicians in your area, is participating in a Medicare demonstration project that uses a simplified payment method to combine all hospital and physician care related to your hospital service.--MA80

60.2 The total Medicare approved amount for your hospital service is _____. Is the Part A Medicare amount for hospital services and _____ is the Part B Medicare amount for physician services (of which Medicare pays 80%). You are responsible for any deductible and coinsurance amounts represented.--The total amount of the hospital payment would be reported in CLP04 on an ERA. MA80 must be sent with the RA data sent the physician and the D99 reason code used to reflect an adjustment to the pre-demonstration

rate as result of the demonstration.

60.3 Medicare has paid _____ for hospital and physician services. Your Part A deductible is _____. Your Part A coinsurance is _____. Your Part B coinsurance is _____.--On a RA, use claim adjustment reason code D98 to report the Part B coinsurance, reason code 1 for the hospital deductible and reason code 2 for hospital coinsurance due from a patient. The amount paid by Medicare must be entered in CLP04.

60.4 This claim is being processed under a demonstration project.--On a RA, this message would vary according to the type of demonstration and the effect of the demonstration on the payment. See the RA instruction issued with that particular demonstration.

**Attachment 2**

## STANDARD CLAIM ADJUSTMENT (CAS) REASON CODES (6/98)

Any reference to procedures or services in the Claim Adjustment Reason Codes apply equally to products, drugs, supplies or equipment. References to prescriptions also include certificates of medical necessity (CMNs). An "*" after a code value denotes that the code value is inactive as of release of version 3040 of the 835. An "^" after a code value denotes that the code value is inactive as of release of version 3050 of the 835. An "'" after a code value denotes that the code value is inactive as of release of version 4010 of the 835. Codes with these symbols may not be used in post 3040, 3050 and/or 4010 versions of the 835 or versions of the NSF 2.0 or later.

This list supersedes earlier CAS reason code lists. The indicated wording may not be modified without approval of the X12 Claim Reason and Status Code Task Group. These codes were developed for use by all U.S. health payers. As result, they are generic, and there are a number of codes that do not apply to Medicare. These are the only CAS reason codes approved for use in Medicare 835, National Standard Format (NSF) and standard Medicare paper remittance advice transactions.

These reason codes report the reasons for any claim financial adjustments, such as denials, reductions or increases in payment. CAS reason codes may be used at the service or claim level, as appropriate. At least one CAS reason code must be used per claim. Code 93, claim paid in full, must be used at the claim level when there have not been any adjustments. Multiple CAS reason codes may be entered for each service or claim as warranted.

Early in the history of CAS reason codes, some codes, such as 69-83 were implemented for informational rather than adjustment purposes. However, these codes and their amounts interfered with balancing of the remittance data. Approval of new codes is now limited to those that involve an adjustment from the amount billed.

There are basic criteria that the X12 Claims Adjustment and Status Task Group considers when evaluating requests for new codes:

1. Can the information be conveyed by the use or modification of an existing CAS reason code?
2. Is the information available elsewhere in the 835?
3. Will the addition of the new CAS reason code make any significant difference in the action taken by the provider who receives the message?

Requests for CAS reason code changes must satisfy these questions prior to approval.

| CAS Code Value | | Message |
|---|---|---|
| 1 | | Deductible Amount |
| 2 | | Coinsurance Amount |
| 3 | | Co-Payment Amount |
| 4 | | The procedure code is inconsistent with the modifier used or a required modifier is missing. |
| 5 | | The procedure code/bill type is inconsistent with the place of service. |
| 6 | | The procedure code is inconsistent with the patient’s age. |
| 7 | | The procedure code is inconsistent with the patient’s sex. |
| 8 | | The procedure code is inconsistent with the provider type. |
| 9 | | The diagnosis is inconsistent with the patient’s age. |
| 10 | | The diagnosis is inconsistent with the patient’s sex. |
| 11 | | The diagnosis is inconsistent with the procedure. |
| 12 | | The diagnosis is inconsistent with the provider type. |
| 13 | | The date of death precedes the date of service. |
| 14 | | The date of birth follows the date of service. |
| 15 | | Claim/service denied because the submitted authorization number is missing or invalid, or does not apply to the billed services. |
| 16 | | Claim/service lacks information which is needed for adjudication. |
| 17 | | Claim/service denied because requested information was not provided or was insufficient/incomplete. |
| 18 | | Duplicate claim/service. |
| 19 | | Claim denied because this is a work-related injury and thus the liability of the Worker’s Compensation carrier. |
| 20 | | Claim denied because this injury is covered by the liability carrier. |
| 21 | | Claim denied because this injury is the liability of the no-fault carrier. |
| 22 | | Claim denied because this care may be covered by another payer per coordination of benefits. |
| 23 | | Claim denied/reduced because charges have been paid by another payer as part of coordination of benefits. |
| 24 | | Payment for charges denied. Charges are covered under a capitation agreement. |
| 25 | | Charges denied. Your stop loss deductible has not been met. |
| 26 | | Expenses incurred prior to coverage. |
| 27 | | Expenses incurred after coverage terminated. |
| 28' | | Coverage not in effect at the time service was provided. |
| 29 | | The time limit for filing has expired. |
| 30 | | Benefits are not available for these services until the patient has met the required waiting or residency period. |
| 31 | | Claim denied as patient cannot be identified as our insured. |
| 32 | | Our records indicate that this dependent is not an eligible dependent as defined. |
| 33 | | Claim denied. Insured has no dependent coverage. |
| 34 | | Claim denied. Insured has no coverage for newborns. |
| 35 | | Benefit maximum has been reached. |
| 36 | * | Balance does not exceed co-payment amount. |
| 37 | * | Balance does not exceed deductible. |
| 38 | | Services not provided or authorized by designated (network) providers. |
| 39 | | Services denied at the time authorization/precertification was requested. |
| 40 | | Charges do not meet qualifications for emergency/urgent care. |
| 41 | * | Discount agreed to in Preferred Provider contract. |
| 42 | | Charges exceed our fee schedule or maximum allowable amount. |

| CAS Code Value | | Message |
|---|---|---|
| 43 | | Gramm-Rudman reduction. |
| 44 | | Prompt-pay discount. |
| 45 | | Charges exceed your contracted/legislated fee arrangement. |
| 46 | | This (these) service(s) is (are) not covered. |
| 47 | | This (these) diagnosis (es) are not covered. |
| 48 | | This (these) procedure(s) is (are) not covered. |
| 49 | | These are non-covered services because this is a routine exam or screening procedure done in conjunction with a routine exam. |
| 50 | | These are non-covered services because this is not deemed a “medical necessity” by the payer. |
| 51 | | These are non-covered services because this is a pre-existing condition. |
| 52 | | The referring/prescribing provider is not eligible to refer/prescribe/order the service billed. |
| 53 | | Services by an immediate relative or a member of the same household are not covered. |
| 54 | | Multiple physicians/assistants are not covered in this case. |
| 55 | | Claim/service denied because procedure/treatment is deemed experimental/investigational by the payer. |
| 56 | | Claim/service denied because procedure/treatment has not been deemed “proven to be effective” by the payer. |
| 57 | | Claim/service denied/reduced because the payer deems the information submitted does not support this level of service, this many services, this length of service, or this dosage. |
| 58 | | Claim/service denied/reduced because treatment was deemed by the payer to have been rendered in an inappropriate or invalid place of service. |
| 59 | | Charges are reduced based on multiple surgery rules or concurrent anesthesia rules. |
| 60 | | Charges for outpatient services with this proximity to inpatient services are not covered. |
| 61 | | Charges reduced as penalty for failure to obtain second surgical opinion. |
| 62 | | Penalty taken for absence of or exceeded pre-certification authorization. |
| 63 | * | Correction to a prior claim. |
| 64 | * | Denial reversed per Medical Review. |
| 65 | * | Procedure code was incorrect. This payment reflects the correct code. |
| 66 | | Blood deductible. |
| 67 | * | Lifetime reserve days. (Handled in QTY, QTY01=LA) |
| 68 | * | DRG weight. (Handled in CLP12) |
| 69 | | Day outlier amount. |
| 70 | | Cost outlier amount. |
| 71 | | Primary payer amount. |
| 72 | * | Coinsurance day. (Handled in QTY, QTY01=CD) |
| 73 | ^ | Administrative days. |
| 74 | | Indirect medical education adjustment. |
| 75 | | Direct medical education adjustment. |
| 76 | | Disproportionate share adjustment. |
| 77 | * | Covered days. (Handled in QTY, QTY01=CA) |
| 78 | | Non-covered days/Room charge adjustment. |
| 79 | ^ | Cost report days. (Handled in MIA15) |
| 80 | ^ | Outlier days. (Handled in QTY, QTY01=OU) |
| 81 | * | Discharges. |
| 82 | * | PIP days. |
| 83 | * | Total visits. |
| 84 | ^ | Capital adjustment. (Handled in MIA) |

| CAS Code Value | Message |
|---|---|
| 85 | Interest amount. |
| 86' | Statutory adjustment. |
| 87 | Transfer amount. |
| 88 | Adjustment amount represents collection against receivable created in prior overpayment. |
| 89 | Professional fees removed from charges. |
| 90 | Ingredient cost adjustment. |
| 91 | Dispensing fee adjustment. |
| 92 * | Claim paid in full. |
| 93' | No claim level adjustments. |
| 94 | Processed in excess of charges. |
| 95 | Benefits reduced. Plan procedures not followed. |
| 96 | Non-covered charges. |
| 97 | Payment is included in the allowance for the basic service/procedure. |
| 98 * | The hospital must file the Medicare claim for this inpatient non-physician service. |
| 99 * | Medicare Secondary Payer adjustment amount. |
| 100 | Payment made to patient/insured/responsible party. |
| 101 | Predetermination, anticipated payment upon completion of services. |
| 102 | Major Medical Adjustment. |
| 103 | Provider promotional discount (i.e. Senior citizen discount) |
| 104 | Managed care withholding. |
| 105 | Tax withholding. |
| 106 | Patient payment option/election not in effect. |
| 107 | Claim/service denied because the related or qualifying claim/service was not paid or identified on the claim. |
| 108 | Claim/service denied/reduced because rent/purchase guidelines were not met. |
| 109 | Claim not covered by this payer/contractor. You must send the claim to the correct payer/contractor. |
| 110 | Billing date predates service date. |
| 111 | Not covered unless the provider accepts assignment. |
| 112 | Claim/service denied/reduced as not furnished directly to the patient and/or not documented. |
| 113 | Claim denied because service/procedure was provided outside of the United States or as result of war. |
| 114 | Procedure/product not approved by the Food and Drug Administration. |
| 115 | Claim/service denied/reduced as procedure postponed or canceled. |
| 116 | Claim/service denied. The advance indemnification notice signed by the patient did not comply with requirements. |
| 117 | Claim/service denied/reduced because transportation is only covered to the closest facility that can provide the necessary care. |
| 118 | Charges reduced for ESRD network support. |
| 119 | Benefit maximum for this time period has been reached. |
| 120 | Patient is covered by a managed care plan. |
| 121 | Indemnification adjustment. |
| 122 | Psychiatric reduction. |
| 123 | Payor refund amount due to overpayment. |
| 124 | Payor refund amount--not our patient. |
| 125 | Claim/service denied/reduced due to a submission/billing error(s). |
| 126 | Deductible--Major Medical. |
| 127 | Coinsurance--Major Medical. |
| 128 | Newborn’s services are covered in the mother’s allowance. |
| 129 | Claim denied--prior processing information appears incorrect. |
| 130 | Paper claim submission fee. |
| 131 | Claim specific negotiated discount. |
| 132 | Prearranged demonstration project adjustment. |
| 133 | This service is suspended pending further review. |

| CAS Code Value | Message |
|---|---|
| A0 | Patient refund amount. |
| A1 | Claim denied charges. |
| A2 | Contractual adjustment. |
| A3^ | Medicare Secondary Payer liability met. |
| A4 | Medicare claim PPS day capital outlier amount. |
| A5 | Medicare claim PPS cost capital outlier amount. |
| A6 | Prior hospitalization or 30-day transfer requirement not met. |
| A7 | Presumptive payment adjustment. |
| A8 | Claim denied. Ungroupable DRG. |
| B1 | Non-covered visits. |
| B2 * | Covered visits. |
| B3 * | Covered charges. |
| B4 | Late filing penalty. |
| B5 | Claim/service denied/reduced because coverage guidelines were not met or were exceeded. |
| B6 | This service/procedure is denied/reduced when performed/billed by this type of provider, by this type of provider in this type of facility, or by a provider of this specialty. |
| B7 | This provider was not certified for this procedure/service on this date of service. |
| B8 | Claim/service not covered/reduced because alternative services were available, and should have been utilized. |
| B9 | Services are not covered because the patient is enrolled in a hospice. |
| B10 | Allowed amount has been reduced because a component of the basic procedure/test was paid. The beneficiary is not liable for more than the charge limit for the basic procedure/test. |
| B11 | The claim/service has been transferred to the proper payer/processor for processing. Claim/service not covered by this payer/processor. |
| B12 | Services not documented in patient’s medical records. |
| B13 | Previously paid. Payment for this claim/service may have been provided in a previous payment. |
| B14 | Claim/service denied because only one visit or consultation per physician per day is covered. |
| B15 | Claim/service denied/reduced because this procedure/service is not paid separately. |
| B16 | Claim/service denied/reduced because “New Patient” qualifications were not met. |
| B17 | Claim/service denied because this service was not prescribed by a physician, not prescribed prior to delivery, the prescription is incomplete, or the prescription is not current. |
| B18 | Claim/service denied because this procedure code/modifier was invalid on the date of service or claim submission. |
| B19' | Claim/service denied/reduced because of the finding of a Review Organization. |
| B20 | Charges denied/reduced because procedure/service was partially or fully furnished by another provider. |
| B21 * | The charges were reduced because the service/care was partially furnished by another physician. |
| B22 | This claim/service is denied/reduced based on the diagnosis. |
| B23 | Claim/service denied because this provider has failed an aspect of a proficiency testing program. |

| CAS Code Value | Message |
|---|---|
| D1' | Claim/service denied. Level of subluxation is missing or inadequate. |
| D2' | Claim lacks the name, strength or dosage of the drug furnished. |
| D3' | Claim/service denied because information to indicate if the patient owns the equipment that requires the part or supply was missing. |
| D4' | Claim/service does not indicate the period of time for which this will be needed. |
| D5' | Claim/service denied. Claim lacks individual lab codes included in the test. |
| D6' | Claim/service denied. Claim did not include patient's medical record for the service. |
| D7' | Claim/service denied. Claim lacks date of patient's most recent physician visit. |
| D8' | Claim/service denied. Claim lacks indicator that "X-ray is available for review." |
| D9' | Claim/service denied. Claim lacks invoice or statement certifying the actual cost of the lens, less discounts, or the type of intraocular lens used. |
| D10' | Claim/service denied. Completed physician financial relationship form not on file. |
| D11' | Claim lacks completed pacemaker registration form. |
| D12' | Claim/service denied. Claim does not identify who performed the purchased diagnostic test or the amount you were charged for the test. |
| D13' | Claim/service denied. Performed by a facility/supplier in which the ordering/referring physician has a financial interest. |
| D14' | Claim lacks indication that the plan of treatment is on file. |
| D15' | Claim lacks indication that service was supervised or evaluated by a physician. |

**For demonstration program use only:**

| | |
|---|---|
| D97 | Physician already paid for services in conjunction with this demonstration claim. You must have the physician withdraw that claim and refund the payment before we can process your claim. |
| D98 | Part B coinsurance. (Part B Center of Excellence Demonstration) |
| D99 | Adjustment to the pre-demonstration rate. |

**ATTACHMENT 3**

**MEDICARE LINE LEVEL REMARK CODES**

Remark codes must be used to relay service-specific Medicare informational messages that cannot be expressed with a reason code. Medicare remark codes are maintained by HCFA. As with the CAS reason codes, Medicare contractors are also prohibited from use of local remark codes.

Remark codes and messages must be used whenever they apply. Although contractors may use their discretion to determine when certain remark codes apply, they do not have discretion as to whether to use an applicable remark code in a remittance notice. A limitation of liability message (M25-M27) must be used where applicable. An unlimited number of Medicare line level remark codes may be entered as warranted in an X12 835 RA; there is a limit of 5 line level remark code entries in a NSF RA and on a standard paper remittance notice.

Line Level Remark Codes

| Code Value | Description |
|---|---|
| M1 | X-ray not taken within the past 12 months or near enough to the start of treatment. |
| M2 | Not paid separately when the patient is an inpatient. |
| M3 | Equipment is the same or similar to equipment already being used. |
| M4 | This is the last monthly installment payment for this durable medical equipment. |
| M5 | Monthly rental payments can continue until the earlier of the 15th month from the first rental month, or the month when the equipment is no longer needed. |
| M6 | You must furnish and service this item for as long as the patient continues to need it. We can pay for maintenance and/or servicing for every 6 month period after the end of the 15th paid rental month or the end of the warranty period. |
| M7 | No rental payments after the item is purchased, or after the total of issued rental payments equals the purchase price. |
| M8 | We do not accept blood gas tests results when the test was conducted by a medical supplier or taken while the patient is on oxygen. |
| M9 | This is the tenth rental month. You must offer the patient the choice of changing the rental to a purchase agreement. |
| M10 | Equipment purchases are limited to the first or the tenth month of medical necessity. |
| M11 | DME, orthotics and prosthetics must be billed to the DME carrier who services the beneficiary's zip code. |
| M12 | Diagnostic tests performed by a physician must indicate whether purchased services are included on the claim. |
| M13 | No more than one initial visit may be covered per specialty per medical group. Visit may be rebilled with an established visit code. |
| M14 | No separate payment for an injection administered during an office visit, and no payment for a full office visit if the patient only received an injection. |
| M15 | Separately billed services/tests have been bundled as they are considered components of the same procedure. Separate payment is not allowed. |
| M16 | Please see the letter or bulletin of (date) for further information. [Note: Contractor must enter the date of the letter/bulletin.] |
| M17 | Payment approved as you did not know, and could not reasonably have been expected to know, that this would not normally have been covered for this patient. In the future, you will be liable for charges for the same service(s) under the same or similar conditions. |
| M18 | Certain services may be approved for home use. Neither a hospital nor a SNF is considered to be a patient's home. |
| M19 | Oxygen certification/recertification (HCFA-484) is incomplete or is required. |
| M20 | HCPCS needed. |
| M21 | Claim for services/items provided in a home must indicate the place of residence. |
| M22 | Claim lacks the number of miles traveled. |
| M23 | Invoice needed for the cost of the material or contrast agent. |
| M24 | Claim must indicate the number of doses per vial. |
| M25 | Payment has been (denied for the/made only for a less extensive) service because the information furnished does not substantiate the need for the (more extensive) service. If you believe the service should have been |

fully covered as billed, or if you did not know and could not reasonably have been expected to know that we would not pay for this (more extensive) service, or if you notified the patient in writing in advance that we would not pay for this (more extensive) service and he/she agreed in writing to pay, ask us to review your claim within six months of receiving this notice. If you do not request review, we will, upon application from the patient, reimburse him/her for the amount you have collected from him/her (for the/in excess of any deductible and coinsurance amounts applicable to the less extensive) service. We will recover the reimbursement from you as an overpayment.

M26 Payment has been (denied for the/made only for a less extensive) service because the information furnished does not substantiate the need for the (more extensive) service. If you have collected (any amount from the patient/any amount that exceeds the limiting charge for the less extensive service), the law requires you to refund that amount to the patient within 30 days of receiving this notice.

The law permits exceptions to the refund requirement in two cases:

- o If you did not know, and could not have reasonably been expected to know, that we would not pay for this service; or
- o If you notified the patient in writing before providing the service that you believed that we were likely to deny the service, and the patient signed a statement agreeing to pay for the service.

If you come within either exception, or if you believe the carrier was wrong in its determination that we do not pay for this service, you should request review of this determination within 30 days of receiving this notice. Your request for review should include any additional information necessary to support your position.

If you request review within the 30-day period, you may delay refunding the amount to the patient until you receive the results of the review. If the review decision is favorable to you, you do not need to make any refund. If, however, the review is unfavorable, the law specifies that you must make the refund within 15 days of receiving the unfavorable review decision.

The law also permits you to request review at any time within six months of receiving this notice. A review requested after the 30-day period does not permit you to delay making the refund. Regardless of when a review is requested, the patient will be notified that you have requested one, and will receive a copy of the determination.

The patient has received a separate notice of this denial decision. The notice advises that he/she may be entitled to a refund of any amounts paid, if you should have known that we would not pay and did not tell him/her. It also instructs the patient to contact your office if he/she does not hear anything about a refund within 30 days.

The requirements for refund are in §1842(l) of the Social Security Act and 42CFR411.408. The section specifies that physicians who knowingly and willfully fail to make appropriate refunds may be subject to civil monetary penalties and/or exclusion from the program.

Please contact this office if you have any questions about this notice.

M27 The beneficiary has been relieved of liability of payment of these items and services under the limitation of liability provision of the law. You, the provider, are ultimately liable for the beneficiary's waived charges, including any charges for coinsurance, since the items or services were not reasonable and necessary or constituted custodial care, and you knew or could reasonably have been expected to know, that they were not covered.

You may appeal this determination provided that the beneficiary does not exercise his/her appeal rights. If the beneficiary appeals the initial determination, you are automatically made a party to the appeals determination. If, however, the beneficiary or his/her representative has stated in writing that he/she does not intend to request a reconsideration, or the beneficiary's liability was entirely waived in the initial determination, you may initiate an appeal.

You may ask for a reconsideration for hospital insurance (or a review for medical insurance) regarding both the coverage determination and the issue of whether you exercised due care. The request for reconsideration

must be filed within 60 days (or 6 months for a medical insurance review) from the date of this notice. You may make the request through any Social Security office or through this office.

M28 This does not qualify for payment under Part B when Part A coverage is exhausted or not otherwise available.
M29 Claim lacks the operative report.
M30 Claim lacks the pathology report.
M31 Claim lacks the radiology report.
M32 This is a conditional payment made pending a decision on this service by the patient's primary payer. This payment may be subject to refund upon your receipt of any additional payment for this service from another payer. You must contact this office immediately upon receipt of an additional payment for this service.
M33 Claim lacks the UPIN of the ordering/referring or performing physician or practitioner, or the UPIN is invalid. (Substitute NPI for UPIN when effective.)
M34 Claim lacks the CLIA certification number.
M35 Claim lacks pre-operative photos or visual field results.
M36 This is the 11th rental month. We cannot pay for this until you indicate that the beneficiary has been given the option of changing the rental to a purchase.
M37 Service not covered when the beneficiary is under age 35.
M38 The patient is liable for the charges for this service as you informed the patient in writing before the service was furnished that Medicare would not pay for it, and the patient agreed to pay.
M39 The patient is not liable for payment for this service as the advance notice of noncoverage you provided the patient did not comply with program requirements.
M40 Claim must be assigned and must be filed by the practitioner's employer.
M41 We do not pay for this as the patient has no legal obligation to pay for this.
M42 The medical necessity form must be personally signed by the attending physician.
M43 Payment for this service previously issued to you or another provider by another Medicare carrier/intermediary.
M44 Incomplete/invalid condition code.
M45 Incomplete/invalid occurrence codes and dates.
M46 Incomplete/invalid occurrence span code and dates.
M47 Incomplete/invalid internal or document control number.
M48 Medicare payment for services furnished to hospital inpatients (other than professional services of physicians) can only be made to the hospital. You must request payment from the hospital rather than the patient for this service.
M49 Incomplete/invalid value code(s) and/or amount(s).
M50 Incomplete/invalid revenue code(s).
M51 Incomplete/invalid, procedure code(s) and/or rates, including “not otherwise classified” or “unlisted” procedure codes.
(Add to message for carriers only: Refer to the HCPCS Directory. If an appropriate procedure code(s) does not exist, refer to Item 19 on the HCFA-1500 instructions.)
M52 Incomplete/invalid “from” date(s) of service.
M53 Did not complete or enter the appropriate number (one or more) of days or units(s) of service.
M54 Did not complete or enter the correct total charges for services rendered.
M55 Medicare does not pay for self-administered anti-emetic drugs that are not administered with a Medicare-covered oral anti-cancer drug.
M56 Incomplete/invalid payer identification.
M57 Incomplete/invalid provider number. (Substitute NPI for provider number when effective.)
M58 Please resubmit the claim with the missing/correct information so that it may be processed.
M59 Incomplete/invalid “to” date(s) of service.
M60 Rejected without appeal rights due to invalid CMN form or format. Resubmit with completed, OMB-approved form or in an approved format.
M61 We cannot pay for this as the approval period for the FDA clinical trial has expired.
M62 Incomplete/invalid treatment authorization code.
M63 Medicare does not pay for more than one of these on the same day.
M64 Incomplete/invalid other diagnosis code.
M65 Only one technical component or interpretation can be submitted per claim when a purchased diagnostic test is indicated. Please submit a separate claim for each technical component code or interpretation code.

| | |
|---|---|
| M66 | Our records indicate that you billed diagnostic tests subject to price limitations and the procedure code submitted includes a professional component. Only the technical component is subject to price limitations. Please submit the technical and professional components of this service as separate line items. |
| M67 | Incomplete/invalid other procedure code(s) and/or date(s). |
| M68 | Incomplete/invalid attending or referring physician identification. |
| M69 | Paid at the regular rate as you did not submit documentation to justify modifier 22. |
| M70 | NDC code submitted for this service was translated to a HCPCS code for Medicare processing, but please continue to submit the NDC on future claims for this item. |
| M71 | Total payment reduced due to overlap of tests billed. |
| M72 | Did not enter full 8-digit date (MM/DD/CCYY). |
| M73 | The HPSA bonus can only be paid on the professional component of this service. Rebill as separate professional and technical components. Use the HPSA modifier on the professional component only. |
| M74 | This service does not qualify for a HPSA bonus payment. |
| M75 | Allowed amount adjusted. Multiple automated multichannel tests performed on the same day combined for payment. |
| M76 | Incomplete/invalid patient's diagnosis(es) and condition(s). |
| M77 | Incomplete/invalid place of service(s). |
| M78 | Did not complete or enter accurately an appropriate HCPCS modifier(s). |
| M79 | Did not complete or enter the appropriate charge for each listed service. |
| M80 | We cannot pay for this when performed during the same session as a previously processed service for the beneficiary. |
| M81 | Patient's diagnosis code(s) is truncated, incorrect or missing; you are required to code to the highest level of specificity. |
| M82 | Service is not covered when beneficiary is under age 50. |
| M83 | Service is not covered unless the beneficiary is classified as at high risk. |
| M84 | Old and New HCPCS cannot be billed for the same date of service. |
| M85 | Subjected to review of physician evaluation and management services. |
| M86 | Service denied because payment already made for similar procedure within set time frame. |
| M87 | Claim/service(s) subjected to CFO-CAP prepayment review.. |
| M88 | We cannot pay for laboratory tests unless billed by the laboratory that did the work. |
| M89 | Not covered more than once under age 40. |
| M90 | Not covered more than once in a 12 month period. |
| M91 | Lab procedures with different CLIA certification numbers must be billed on separate claims. |
| M92 | Services subjected to review under the Home Health Medical Review Initiative. |
| M93 | Information supplied supports a break in therapy. A new capped rental period began with delivery of this equipment. |
| M94 | Information supplied does not support a break in therapy. A new capped rental period will not begin. |
| M95 | Services subjected to Home Health Initiative medical review/cost report audit. |
| M96 | The technical component of a service furnished to an inpatient may only be billed by that inpatient facility. You must contact the inpatient facility for technical component reimbursement. If not already billed, you should bill us for the professional component only. |
| M97 | Not paid to practitioner when provided to patient in this place of service. Payment included in the reimbursement issued the facility. |
| M98 | Begin to report the Universal Product Number on claims for items of this type. We will soon begin to deny payment for items of this type if billed without the correct UPN. |
| M99 | Incomplete/invalid/missing Universal Product Number. |
| M100 | We do not pay for an oral anti-emetic drug that is not administered for use immediately before, at, or within 48 hours of administration of a covered chemotherapy drug. |
| M101 | Begin to report a G1-G5 modifier with this HCPCS. We will soon begin to deny payment for this service if billed without a G1-G5 modifier. |
| M102 | Service not performed on equipment approved by the FDA for this purpose. |
| M103 | Information supplied supports a break in therapy. However, the medical information we have for this beneficiary does not support the need for this item as billed. We have approved payment for this item at a reduced level, and a new capped rental period will begin with the delivery of this equipment. |
| M104 | Information supplied supports a break in therapy. A new capped rental period will begin with delivery of the equipment. This is the maximum approved under the Medicare fee schedule for this item or service. |
| M105 | Information supplied does not support a break in therapy. The medical information we have for this beneficiary does not support the need for this item as billed. We have approved payment for this item at a reduced level, and a new capped rental period will not begin. |

M106 Information supplied does not support a break in therapy. A new capped rental period will not begin. This is the maximum approved under the Medicare fee schedule for this item or service.

M107 Payment reduced as 90-day rolling average hematocrit for ESRD patient exceeded 36.5%.

M108 Must report the PIN of the physician who interpreted the diagnostic test. (Substitute NPI for PIN when effective.)

M109 We have provided you with a bundled payment for a teleconsultation. You must send 25 percent of the teleconsultation payment to the referring physician.

M110 Missing/invalid provider number for the provider from whom you purchased interpretation services.

M111 and following. Reserved for future use.

MEDICARE CLAIM LEVEL REMARKS CODES

A maximum of 5 of these claim level Medicare Inpatient Adjudication (MIA) and 5 of these claim level Medicare Outpatient Adjudication (MOA) remarks codes may be used per claim. See the Medicare 835 Implementation Guides. Insert these codes in the space for semantics 5 or 20-23 of the MIA segment or semantics 3-7 of the MOA segment as applicable. These semantics were previously reserved for local message codes. Previously established MIA/MOA semantic codes [MIA01, 03-04, 06-19 and 24, and MOA01-02 and 08-09] are not impacted by this instruction and must continue to be used as indicated in the Medicare Part A 835 Implementation Guide. MIA01, 03-04, 06-19 and 24, and MOA01-02 and 08-09 as listed in the Part A 835 Implementation Guide do not apply to the NSF, but individual Medicare MIA/MOA remarks codes listed in this document must also be used in the NSF and the standard paper remittance notice. See NSF and standard paper remittance notice specifications for use of Medicare MIA/MOA remarks codes in NSF and paper RAs.

Medicare MIA/MOA remarks codes are used to convey appeal information and other claim-specific information that does not involve a financial adjustment. As with the 835/NSF reason and Medicare line level remarks codes, Medicare contractors are also prohibited from use of local MIA/MOA codes.

An appropriate appeal, limitation of liability or other message must be used whenever applicable. Although contractors have discretion to determine when certain remarks codes and messages apply, they do not have discretion as to whether to use applicable codes and messages.

| Code Value | Description |
|---|---|
| MA01 | (Initial Part B determination, carrier or intermediary)--If you do not agree with what we approved for these services, you may appeal our decision. To make sure that we are fair to you, we require another individual that did not process your initial claim to conduct the review. However, in order to be eligible for a review, you must write to us within 6 months of the date of this notice, unless you have a good reason for being late.<br><br>(Note: An Intermediary must add: An institutional provider, e.g., hospital, SNF, HHA may appeal only if the claim involves a medical necessity denial, a SNF recertified bed denial, or a home health denial because the patient was not homebound or was not in need of intermittent skilled nursing services, and either the patient or the provider is liable under §1879 of the Social Security Act, and the patient chooses not to appeal.)<br><br>(NOTE: Carriers who issue telephone review decisions should add: If you meet the criteria for a telephone review, you should phone this office if you wish to request a telephone review.) |
| MA02 | (Initial Part A determination)--If you do not agree with this determination, you have the right to appeal. You must file a written request for a reconsideration within 60 days of receipt of this notification. Decisions made by a PRO must be appealed to that PRO. (An institutional provider, e.g., hospital, SNF, HHA, may appeal only if the claim involves a medical necessity denial, a SNF noncertified bed denial, or a home health denial because the patient was not homebound or was not in need of intermittent skilled nursing services, and either the patient or the provider is liable under §1879 of the Social Security Act, and the patient chooses not to appeal.) |
| MA03 | (Hearing)--If you do not agree with the Medicare approved amounts and $100 or more is in dispute (less deductible and coinsurance) , you may ask for a hearing. You must request a hearing within six months of the date of this notice. To meet the $100, you may combine amounts on other claims that have been reviewed/reconsidered. This includes reopened reviews if you received a revised decision. You must appeal each claim on time. At the hearing, you may present any new evidence which could affect our decision.<br><br>(Note: An Intermediary must add: An institutional provider, e.g., hospital, SNF, HHA, may appeal only if the claim involves a medical necessity denial, a SNF noncertified bed denial, or a home health denial because the patient was not homebound or was not in need of intermittent skilled nursing services, and either the patient or the provider is liable under §1879 of the Social Security Act, and the patient chooses not to appeal.) |

MA04 Secondary payment cannot be considered without the identity of or payment information from the primary payer. The information was either not reported or was illegible.

MA05 Incorrect admission date, patient status or type of bill entry on claim.
(NOTE: See MA30, MA40 and MA43 also.)

MA06 Incorrect beginning and/or ending date(s) on claim.

MA07 The claim information has also been forwarded to Medicaid for review.

MA08 You should also submit this claim to the patient's other insurer for potential payment of supplemental benefits. We did not forward the claim information as the supplemental coverage is not with a Medigap plan, or you do not participate in Medicare.

MA09 Claim submitted as unassigned but processed as assigned. You agreed to accept assignment for all claims.

MA10 The patient's payment was in excess of the amount owed. You must refund the overpayment to the patient.

MA11 Payment is being issued on a conditional basis. If no-fault insurance, liability insurance, Workers' Compensation, Department of Veterans Affairs, or a group health plan for employees and dependents also covers this claim, a refund may be due us. Please contact us if the patient is covered by any of these sources.

MA12 You have not established that you have the right under the law to bill for services furnished by the person(s) that furnished this (these) service(s).

MA13 You may be subject to penalties if you bill the beneficiary for amounts not reported with the PR (patient responsibility) group code.

MA14 Patient is a member of an employer-sponsored prepaid health plan. Services from outside that health plan are not covered. However, as you were not previously notified of this, we are paying this time. In the future, we will not pay you for non-plan services.

MA15 Your claim has been separated to expedite handling. You will receive a separate notice for the other services reported.

MA16 The patient is covered by the Black Lung Program. Send this claim to the Department of Labor, Federal Black Lung Program, P.O. Box 828, Lanham-Seabrook MD 20703.

MA17 We are the primary payer and have paid at the primary rate. You must contact the patient's other insurer to refund any excess it may have paid due to its erroneous primary payment.

MA18 The claim information is also being forwarded to the patient's supplemental insurer. Send any questions regarding supplemental benefits to them.

MA19 Information was not sent to the Medigap insurer due to incorrect/invalid information you submitted concerning that insurer. Please verify your information and submit your secondary claim directly to that insurer.

MA20 SNF stay not covered when care is primarily related to the use of an urethral catheter for convenience or the control of incontinence.

MA21 SSA records indicate mismatch with name and sex.

MA22 Payment of less than $1.00 suppressed.

MA23 Demand bill approved as result of medical review.

MA24 Christian Science Sanitorium/ SNF bill in the same benefit period.

MA25 A patient may not elect to change a hospice provider more than once in a benefit period.

MA26 Our records indicate that you were previously informed of this rule.

MA27 Incorrect entitlement number or name shown on the claim. Please use the entitlement number or name shown on this notice for future claims for this patient.

MA28 Receipt of this notice by a physician or supplier who did not accept assignment is for information only and does not make the physician or supplier a party to the determination. No additional rights to appeal this decision, above those rights already provided for by regulation/instruction, are conferred by receipt of this notice.

MA29 Incomplete/invalid provider name, city, state, and zip code.

MA30 Incomplete/invalid type of bill.

MA31 Incomplete/invalid beginning and ending dates of the period billed.

MA32 Incomplete/invalid number of covered days during the billing period.

MA33 Incomplete/invalid number of noncovered days during the billing period.

MA34 Incomplete/invalid number of coinsurance days during the billing period.

MA35 Incomplete/invalid number of lifetime reserve days.

MA36 Incomplete/invalid patient's name.

MA37 Incomplete/invalid patient's address. (Note: When used, a Medicare contractor must verify that an address, with city, State, and zip code, and a phone number are present.)

MA38 Incomplete/invalid patient's birthdate.

MA39 Incomplete/invalid patient's sex.

MA40 Incomplete/invalid admission date.

MA41 Incomplete/invalid type of admission.
MA42 Incomplete/invalid source of admission.
MA43 Incomplete/invalid patient status.
MA44 No appeal rights on this claim. Every adjudicative decision based on Medicare law.
MA45 As previously advised, a portion or all of your payment is being held in a special account.
MA46 The new information was considered, however, additional payment cannot be issued. Please review the information listed for the explanation.
MA47 Our records show you have opted out of Medicare, agreeing with the patient not to bill Medicare for services/tests/supplies furnished. As result, we cannot pay this claim. The patient is responsible for payment
MA48 Incomplete/invalid name and/or address of responsible party or primary payer .
MA49 Incomplete/invalid six-digit Medicare provider number of home health agency or hospice for physician(s) performing care plan oversight services.
MA50 Incomplete/invalid Investigational Device Exemption number for FDA-approved clinical trial services.
MA51 Incomplete/invalid CLIA certification number for laboratory services billed by physician office laboratory.
MA52 Did not enter full 8-digit date (MM/DD/CCYY).
MA53 Inconsistent demonstration project information. Correct and resubmit with information on no more than one demonstration project.
MA54 Physician certification or election consent for hospice care not received timely.
MA55 Not covered as patient received medical health care services, automatically revoking his/her election to receive religious non-medical health care services.
MA56 Our records show you have opted out of Medicare, agreeing with the patient not to bill Medicare for services/tests/supplies furnished. As result, we cannot pay this claim. The patient is responsible for payment, but under Federal law, you cannot charge the patient more than the limiting charge amount.
MA57 Patient submitted written request to revoke his/her election for religious non-medical health care services.
MA58 Incomplete release of information indicator.
MA59 The beneficiary overpaid you for these services. You must issue the beneficiary a refund within 30 days for the difference between his/her payment and the total amount shown as patient responsibility on this notice.
MA60 Incomplete/invalid patient's relationship to insured.
MA61 Did not complete or enter correctly the patient's social security number or health insurance claim number.
MA62 Telephone review decision
MA63 Incomplete/invalid principal diagnosis code.
MA64 Our records indicate that Medicare should be the third payer for this claim. We cannot process this claim until we have received payment information from the primary and secondary payers.
MA65 Incomplete/invalid admitting diagnosis.
MA66 Incomplete/invalid principal procedure code and/or date.
MA67 Correction to a prior claim.
MA68 We did not crossover this claim because the secondary insurance information on the claim was incomplete. Please supply complete information or use the PAYERID of the insurer to assure correct and timely routing of the claim.
MA69 Incomplete/invalid remarks.
MA70 Incomplete provider representative signature.
MA71 Incomplete/invalid provider representative signature date.
MA72 The beneficiary overpaid you for these assigned services. You must issue the beneficiary a refund within 30 days for the difference between his/her payment to you and the total of the amount shown as patient responsibility and as paid to the beneficiary on this notice.
MA73 Informational remittance associated with a Medicare demonstration. No payment issued under fee-for-service Medicare as patient has elected managed care.
MA74 This payment replaces an earlier payment for this claim that was either lost, damaged or returned.
MA75 Our records indicate neither a patient's or authorized representative's signature was submitted on the claim. Since this information is not on file, please resubmit.
MA76 Incomplete/invalid provider number of HHA or hospice when physician is performing care plan oversight services.
MA77 The beneficiary overpaid you. You must issue the beneficiary a refund within 30 days for the difference between the beneficiary's payment less the total of Medicare and other payer payments and the amount shown as patient responsibility on this notice.
MA78 The beneficiary overpaid you. You must issue the beneficiary a refund within 30 days for the difference between the Medicare allowed amount total and the amount paid by the beneficiary.
MA79 Billed in excess of interim rate.

MA80 Informational notice. No payment issued for this claim with this notice. Medicare payment issued to the hospital by its intermediary for all services for this encounter under a demonstration project.

MA81 Our records indicate neither a physician or supplier signature is on the claim or on file.

MA82 Did not complete or enter the correct physician/supplier's Medicare billing number/NPI and/ or billing name, address, city, state, zip code, and phone number.

MA83 Did not indicate whether Medicare is the primary or secondary payer. Refer to Item 11 in the HCFA-1500 instructions for assistance.

MA84 Patient identified as participating in the National Emphysema Treatment Trial but our records indicate that this patient is either not a participant, or has not yet been approved for this phase of the study. Contact Johns Hopkins University, the study coordinator, to resolve if there was a discrepancy.

MA85 Our records indicate that a primary payer exists (other than Medicare); however, you did not complete or enter accurately the primary payer's plan or program name. (Substitute "PAYERID" for "their plan or program name" when effective.)

MA86 Our records indicate that there is insurance primary to Medicare; however, you either did not complete or enter accurately the group or policy number of the insured.

MA87 Our records indicate that a primary payer exists (other than Medicare); however, you did not complete or enter accurately the correct insured's name.

MA88 Our records indicate that a primary payer exists (other than Medicare); however, you did not complete or enter accurately the insured's address and/or telephone number.

MA89 Our records indicate that a primary payer exists (other than Medicare); however, you did not complete or enter the appropriate patient's relationship to the insured.

MA90 Our records indicate that there is insurance primary to Medicare; however, you either did not complete or enter accurately the employment status code of the primary insured.

MA91 This determination is the result of the appeal you filed.

MA92 Our records indicate that there is insurance primary to Medicare; however, you did not complete or enter accurately the required information.
(NOTE: Carriers must also add: Refer to the HCFA-1500 instructions on how to complete MSP information.)

MA93 Non-PIP claim.

MA94 Did not enter the statement "Attending physician not hospice employee" on the claim to certify that the rendering physician is not an employee of the hospice. Refer to item 19 on the HCFA-1500.

MA95 A "not otherwise classified" or "unlisted" procedure code(s) was billed, but a narrative description of the procedure was not entered on the claim. Refer to item 19 on the HCFA-1500.

MA96 Claim rejected. Coded as a Medicare Managed Care Demonstration but patient is not enrolled in a Medicare managed care plan.

MA97 Claim rejected. Does not contain the Medicare Managed Care Demonstration contract number, however, the beneficiary is enrolled in a Medicare managed care plan.

MA98 Claim rejected. Does not contain the correct Medicare Managed Care Demonstration contract number for this beneficiary.

MA99 Our records indicate that a Medigap policy exists; however, you did not complete or enter accurately any of the required information. Refer to the HCFA-1500 instructions on how to complete a mandated Medigap transfer.

MA100 Did not complete or enter accurately the date of current illness, injury or pregnancy.

MA101 A SNF is responsible for payment of outside providers who furnish these services/supplies to residents.

MA102 Did not complete or enter accurately the referring/ordering/supervising physician's/practitioner's name and/or UPIN. (Substitute "NPI" for "UPIN" when effective.)

MA103 Hemophilia Add On

MA104 Did not complete or enter accurately the date the patient was last seen and/or the UPIN of the attending physician. (Substitute "NPI" for "UPIN" when effective.)

MA105 Missing/invalid provider number for this place of service. Place of service code shown as 21, 22, or 23 (hospital). (Substitute "NPI" for provider number when effective.)

MA106-109 Reserved for future use

MA110 Our records indicate that you billed diagnostic test(s) subject to price limitations; however, you did not indicate whether the test(s) were performed by an outside entity or if no purchased tests are included on the claim.

MA111 Our records indicate that you billed diagnostic test(s) subject to price limitations and indicated that the test(s) were performed by an outside entity; however, you did not indicate the purchase price of the test(s) and/or the performing laboratory's name and address.

MA112 Our records indicate that the performing physician/supplier/practitioner is a member of a group practice; however, you did not complete or enter accurately their carrier assigned individual and group PINs. (Substitute “NPI” for “PIN” when effective.)

MA113 Incomplete/invalid taxpayer identification number (TIN) submitted by you per the Internal Revenue Service. Your claims cannot be processed without your correct TIN, and you may not bill the patient pending correction of your TIN. There are no appeal rights for unprocessable claims, but you may resubmit this claim after you have notified this office of your correct TIN.

MA114 Did not complete or enter accurately the name and address, or the carrier assigned PIN, of the entity where services were furnished. (Substitute “NPI” for “PIN” when effective.)

MA115 Our records indicate that you billed one or more services in a Health Professional Shortage Area (HPSA); however, you did not enter the physical location (name and address, or PIN) where the service(s) were rendered. (Substitute “NPI” for “PIN” when effective.)

MA116 Did not complete the statement "Homebound" on the claim to validate whether laboratory services were performed at home or in an institution.

MA117 This claim has been assessed a $1.00 user fee.

MA118-119 Reserved for future use

MA120 Did not complete or enter accurately the CLIA number.

MA121 Did not complete or enter accurately the date the X-Ray was performed.

MA122 Did not complete or enter accurately the initial date "actual" treatment occurred.

MA123 Your center was not selected to participate in this study, therefore, we cannot pay for these services.

MA124-127 Reserved for future use

MA128 Did not complete or enter accurately the six digit FDA approved, identification number.

MA129 This provider was not certified for this procedure on this date of service. Effective 1/1/98, we will begin to deny payment for such procedures. Please contact _____ to correct or obtain CLIA certification. (Claim processor must provide the name and phone number of the State Agency to be contacted.)

MA130 Your claim contains incomplete and/or invalid information, and no appeal rights are afforded because the claim is unprocessable. Please submit a new claim with the complete/correct information.

MA131 and higher Reserved for future use